EDUCATIONAL PROGRAMS ON AGING PROJECT

TRAINING FOR SERVICE PROVIDERS

F I N A L R E P O R T

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E D U C A T I O N A L P R O G R A M S O N A G I N G

TRAINING FOR SERVICE PROVIDERS

Curriculum and Evaluation

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EDUCATIONAL PROGRAMS ON AGING

The Educational Programs on Aging Project was funded by the Health Promotion Directorate of Health and Welfare Canada. A grant of $205,150 was provided to the P.E.I. Department of Health and Social Services to conduct the Project from January, 1984, to July, 1986.

The goal of the Project was to create educational opportunities which would "improve knowledge and attitudes about the elderly, about the aging process, and about the influence of good health and positive attitudes on aging." [1]

Three staff (two Educational Specialists and one Secretary) were hired under the grant. An Advisory Council was established in the spring of 1984 and was made up of individuals with skills, interests, and experience in community service delivery, the educational system, and citizen advocacy. They met quarterly with the Project staff and acted as advisors, ambassadors, and assistants to the work as it progressed.

The Project had two main components:

The Intergenerational Program was designed to bring young and old people together in schools and other community settings. Activities and subjects focused on aging as a normal process; on the skills and experience that the elderly can share with the young; and on projects of mutual interest which encouraged the development of close relationships.

1. Joshi, Anju, Educational Programs on Aging: Proposal by the Division of Services to the Aging, P.E.I. Department of Health and Social Services, April, 1982, P i.

The Training for Service Providers component provided educational opportunities to those who work with the elderly in the community--public health nurses, natural caregivers, homemakers, therapists, etc. A variety of topics were addressed in the areas of gerontology, geriatrics, service delivery models, philosophy of care, and personal awareness about aging.

This document is the final report of the Training for Service Providers component, prepared by Kevin Moynihan. It records the highlights of the past two and one-half years. There is a second document on the Intergenerational Program component which was prepared by Eileen Conway-Martin.

I want to express my appreciation to the many, many people who have contributed so much to the Project--members of the Advisory Council, school administrations, community and professional organizations, health and social service agencies, Audio-Visual Services, Holland College, P.E.I. Department of Education, and our own Department of Health and Social Services. We have been very richly blessed along the way with skilled resource people, enthusiastic participants of all ages, and willing organizers, many of whom volunteered their time and energy out of sheer commitment to the idea and its possibilities.

Also, I want to thank the staff of the Health Promotion Directorate for their guidance and support. And last but not least, I want to thank Kevin, Eileen, and Beryl Burke for their dedication to the task and the team; their insights, abilities, and enthusiasm; and their sense of humour which always managed to see us through the rough spots.

It has been a pleasure. Best wishes to all of you.

Janet Yuill
Project Supervisor
September, 1986

SECTION I - EVALUATION

SECTION II - CURRICULUM

SECTION III - THE TRAINING MANUAL ON AGING

SECTION I

EVALUATION

CONTENTS

	Page
EVALUATION	1
OBJECTIVES AND GOALS	1
EDUCATIONAL PHILOSOPHY	2
METHODOLOGY	3
Pattern One - Drugs and the Elderly	3
Pattern Two - Foot Care	7
Pattern Three - Speech and Communication	10
Pattern Four - Oral Care of the Elderly	14
Pattern Five - Symposia	18
TOOLS AND MODELS	19
RESULTS	28
DISCUSSION	31
CONCLUDING STATEMENT	39
APPENDIX - A letter of evaluation	41

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EVALUATION

This half of the project saw a variety of educational events, workshops, conferences, radio documentaries, video packages, audio tapes, and articles written for the purpose of assisting service providers to the elderly to clarify and improve their attitudes about aging.

The assumption has been that if the service provider approaches the older client/patient with a more positive attitude about aging, then the quality of the care would be improved. A more positive and understanding service provider/caregiver will offer a higher level of care than a service provider who might view aging as a disease and the older person as having very little potential.

In the original proposal (dated April, 1982), the goal for the Educational Programs on Aging Project was stated this way:

> "The goal of the proposed Educational Programs on Aging Project is to improve people's knowledge/attitudes about the elderly, about the aging process, and about the influence of good health and positive attitudes on aging."

OBJECTIVES AND GOALS

The goals of the Training for Service Providers portion were:

i To encourage service providers in such areas as health, social services, recreation, housing, volunteer home help, natural caregivers, etc. to support seniors' attempts to continue living in the community.

ii To give professionals and other service providers the opportunity to better understand the aging process and the variety of needs of seniors.

iii To begin to dispel negative attitudes, stereotypes, and myths about old age.

iv To provide training opportunities to service providers to help them work effectively with elderly people.

v To design educational opportunities for service providers on the importance of promoting the prevention of illness.

vi To encourage the incorporation of content in the programs of universities, colleges, and professional schools regarding the developmental potential of the elderly.

EDUCATIONAL PHILOSOPHY

The educational philosophy of the training for service providers portion is based on some assumptions about the process of attitude clarification and change. The training for service providers component began by making some assumptions about 'the service provider.'

Assumption one: The service provider would be, normally, resistant to attitude change if invited to attend an 'attitude change' educational event. This is normal social psychology.

Assumption two: The service provider--professional or volunteer--is a practical, hands-on-person who views educational events as opportunities to learn how to be a better nurse, etc. Therefore, the educational event should have skills as a major component.

Assumption three: Ideas, good as they are, don't change people's attitudes very effectively. A more potent mix of those same good ideas evident in the life and work of peers is probably more effective. Therefore, we concluded that the resource people for the workshops, audio visual material, and conferences have to be role-models as well as well-informed professionals.

Workshops are Planned

With these three assumptions clarified, we proceeded to plan and implement workshops and material that would help the service provider to acquire more positive attitudes about aging and the older client.

METHODOLOGY

The week-to-week events are available in the monthly reports on file; however, this section will cite some highlights with a view to identifying some patterns.

Pattern One - Drugs and the Elderly

One of the concerns of service providers to the elderly is the amount and nature of drugs used by older people. In North America, people over sixty-five years of age represent about ten percent of the population and yet they consume twenty-five percent of the prescribed drugs.

Drugs can be put into two large categories. The first is physical like antibiotics or diuretics (for water retention) and the second is mood altering like valium. All drugs, prescribed and over-the-counter, have an impact on the health status or life-style of older people.

With this concern in mind, I developed a 16-minute documentary video entitled CAN'T YOU GIVE 'EM SOMETHING in **April, 1984.** The video sheds a little light on the question of 'over-prescribed' elderly people by presenting a successful example of a drug-reduction program at Summerset Manor in Summerside.

This video has received some positive critical review from health professionals in different parts of Canada. Requests for copies have come from many different quarters: a community college in British Columbia, a drug addiction service in Alberta; hospitals in Nova Scotia, and so on.

July 24, 1984, Dr. Gilbert Rosenberg delivered lectures on drug interaction in Charlottetown and Kensington. The lectures were well attended and audio tapes of these presentations were widely distributed throughout Prince Edward Island.

September - October, 1984, I wrote and assisted in producing a 15-minute radio documentary for CBC Radio on DRUG USE AND THE ELDERLY. The show aired on October 9 at 4:30 p.m.

This led to some serious discussion on the great potential of the electronic media in assisting attitude change.

Summer - 1984 - The Kensington Team, A multi-disciplinary team composed of a public health nurse, a dentist, a physician, and a pharmacist in Kensington was developed. The team met with Dr. Rosenberg on his visit for an evening of discussion and a morning of lectures. The lectures covered drug interaction and systemic diseases that result from immobility in the older patient.

The pharmacist, Ken Ramsay, emerged here as a key player. He became interested in advocacy on behalf of the elderly. Later in the fall, I asked Ken Ramsay to join the planning committee for Symposium '85.

Survey of Atlantic Family Physicians

October, 1984, I had the opportunity to design a survey questionnaire to be given to 150 physicians meeting in Charlottetown. The question: What are your major continuing education needs for geriatric practice?

The scoring was simple--rank from 1-5, the most important issues out of 12 examples provided. The **two** highest scores were: (1) drugs and drug therapy for the older patient at 3.9 out of 5, and (2) drugs and drug interaction in the elderly at 3.8 of a possible 5.

October, CAN'T YOU GIVE 'EM SOMETHING, I presented this video to the Canadian Association of Addiction Nurses meeting in Summerside. They loved it and all wanted copies.

November, 1984, Vancouver - I presented CAN'T YOU GIVE 'EM SOMETHING to the Canadian Association on Gerontology convention in Vancouver--many requests for copies.

February, 1985, Doctors and Drugs - Dr. Mike Fleming, Director of Continuing Medical Education for Dalhousie University, and I collaborated on Symposium '85 (July/85). He requested a special workshop on drug therapy and incontinence in the elderly for physicians who would be attending the Stream A program of the symposium.

July, 1985, Symposium '85 - Some 220 service providers, dentists, doctors, nurses, LNA's, resident care workers, recreational therapists, administrators, etc. came to Charlottetown from all over the Island, the Atlantic region, and one from British Columbia. The topics concerned: drugs, drug therapy, drug interactions, as well as many other gerontological issues. (See documentation in curriculum portion of the evaluation for more details.)

July, 1985, CBC-TV Drug Documentary - Produced and aired on July 16 - a documentary on drugs and the older person on Compass, 6-7 p.m. The audience for the program is 30,000 Islanders. The estimates of tourists and visitors is not available. Since the population is 125,000 people, we can conclude that one-in-four Islanders viewed this well-produced documentary. The documentary is identical to Can't You Give 'em Something in format and content.

Symposium '86 - Pharmacists attended a special session at Symposium '86 (June) featuring a breakfast meeting with Brian Tuttle, pharmacist at Camp Hill Hospital. The point of the session was to encourage those who dispense drugs to become more informed about the drastic consequences of poly-pharmacy and drug interaction on older people.

The pattern that evolved through these drug workshops was an even more important role for the local pharmacist as an advocate on behalf of the older person.

EPA then has made a contribution to this evolution of role by providing an educational component for the process.

Footnote

A strange and interesting footnote on this pattern. Two major drug companies took an interest in the video material produced by the EPA project. U.S.V. Canada Inc. asked for two copies of Can't You Give 'em Something for use in their workshops with service providers to the elderly; and Dow-Merrell requested copies of Can't You Give 'em Something and In a Land of Plenty* for the same purpose. We studied both requests since they appear to be strange bedfellows and decided to provide copies to these pharmaceutical companies.

INSIGHT - Pattern One

More awareness about the effect of drugs on the older person can lead to more informed advocacy on behalf of the older person. The older person becomes better informed by viewing public media (radio - TV) on the question and, in turn, becomes a better advocate for himself. We used radio, TV, community school courses, and workshops to present more information and to help change the attitude about drugs and the elderly from one of complacency where aging is perceived as a disease and; therefore, treated by pharmaceutical therapy to one where aging is perceived as a natural process where drugs are used as therapy only for specific ailments. A lucid older person is an active older person who can defy stereotyping and contribute more significantly to the society.

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*In a Land of Plenty - 12-minute video on causes of malnutrition in the elderly who live in the community.

Pattern Two - Foot Care

The funding for the Educational Programs on Aging Project came from the Health Promotion Directorate of Health and Welfare Canada. Here was an opportunity to spend Health Promotion dollars in a way that resulted in healthier and more active lifestyles for seniors. Quite simply, increased awareness of how to properly care for one's feet would lead to a more mobile elderly population in the long run.

With the establishment of the EPA project in 1984, a process of training for service providers to the elderly was begun. The primary focus of the EPA project was attitudes about aging; however, the vehicle chosen was skills-based. In other words, service providers came to workshops that were designed to improve their skills in serving the older client and in the process, were exposed to a more enlightened and sympathetic view on aging. This process began to uncover certain specific needs in the elderly community.

One very clear need was mobility, not public transit, taxis, and other mechanized modes, but quite simply, mobility of the first order. Older people want to be able to walk with a degree of comfort and without excessive pain. This did not appear to be an unreasonable request. The question then was, how do we assist people to accomplish this end?

Foot care was nothing new to those involved in public health, but it became clear that the attention to the elderly foot and also to foot wear for the elderly could assist older Islanders to remain more active and involved in the community. Add to this the fact that a foot care specialist, an occupational therapist in orthotics, and a geriatrician have developed expertise in this field in Ontario (Kingston). The EPA project became the occasion for putting all these elements together.

April, 1984: an occupational therapist in the western part of Prince Edward Island, Jude Driscoll, and a public health nurse in Montague, in the east, Roma Shaw, had surfaced as advocates for improved foot care. The EPA team assisted these two people in attending the FOOT CARE AND MANAGEMENT OF COMMON FOOT PROBLEMS clinic in Kingston, Ontario, in April of 1984. Upon her return, Jude was paid by EPA for workshops that she animated for service providers to the elderly in West Prince county. The EPA Gerontology Resource Person also arranged to pay Roma Shaw for workshops animated for EPA upon her return.

Roma Shaw, P.H.N., and Jude Driscoll, O.T., then became the "Island Team" for training for service providers in the area of foot care. Workshops were organized in different regions of the province in 1984.

Geriatrician Invited to Present on Foot Problems

July, 1984: EPA arranged for Dr. Gilbert Rosenberg of St. Mary's of the Lake Hospital, Kingston, to give three days of lectures on drugs, interactions, and foot problems of the elderly. The lectures were very well attended and more momentum was added to the foot care area.

Fall of 1984, and **Spring of 1985:** More workshops and inservice with nurses, physicians, licenced nursing assistants, and seniors themselves on foot care and foot wear.

Spring, 1985: Roma Shaw returns to Kingston to attend the second level of the foot care clinic.

Summer, 1985: EPA arranged Symposium '85 at Holland College, Charlottetown, where Dr. George Merry, one of the prime movers in the foot care clinic from Kingston, gave lectures on proper foot care and management. His lectures were very popular as were the training sessions given by Roma and Jude on foot wear and care of the feet at the same symposium.

Fall of 1985, and Spring of 1986: Requests for workshops on foot care began to come in to the EPA office. Jude returned to Kingston in the spring of '86 for updating and four extensive days with Lynne Rutherford, O.T., the other prime mover in this field in Kingston at St. Mary's of the Lake hospital.

Spring, 1986: Requests for Jude and Roma are coming in now and we at EPA are not able to supply. Hospitals, private nursing homes, Holland College (Resident Care Workers Program) and provincially-run manors all want workshops.

Symposium '86 - June 23-27: The last week of June was a week of workshops on foot care and foot wear for P.E.I. Three pre-conference events at Queen Elizabeth Hospital, as well as a series of lectures on foot care at the symposium were a response to the tremendous demand for more information and inservice.

The staff person drafted a proposal for training a number of nurses and home care professionals in the new techniques of foot managment. The proposal was then given to the Director of Nursing and the Director of Home Care and Support along with a cost sheet and enough documentation to make a good case for future departmental decisions in this area.

INSIGHT - Pattern Two

Health care dollars were spent on the EPA project. Mobility of seniors was seen as a prerequisite for an active senior population. Proper foot care and foot wear were identified as the means to increased mobility and the whole process was in motion.

The conclusion to all of this: Health Promotion funding translated into an increased awareness of a problem and a solution to the problem was developed and assisted by the EPA project. It is not often that such a "Quid Pro Quo" or a healthier lifestyle for seniors is as evident as a result of Health Promotion funding.

Pattern Three - Speech and Communication

In Article 19 of the Universal declaration of Human Rights, it is written that "everyone has the right to freedom of opinion and expression," and it goes on to say that the freedom to "seek, receive, and impart information and ideas through any media and regardless of frontiers" is also guaranteed.

The right to express oneself in any media and regardless of frontiers could be read in terms of an obligation on the part of caregivers to the elderly to assist the "communicatively disabled" elderly to impart their ideas, wants, and needs using media other than the fluent spoken word.

Consider the retired school teacher who once enjoyed a fluency and facility in language that capitvated the young minds of her students in their study of English literature. Now after a CVA/stroke, this gentle woman cannot speak the words that are in her mind. The wrong words and expressions come out and her young visitors are a little dismayed and frankly embarrassed at being unable to "get through" to the former teacher.

As caregivers, do we have any responsibility to assist this elder to express herself and to reach her potential level of recovery as soon as possible? Or do we say, "Well, she's old, I'm making her comfortable and what's she got to say anyway"?

The difference between these responses reflects attitudes about aging that exist in the community. Unfortunately, the second--a negative one--is more prevalent in the general population as well as the specific service provider population.

If we consider that older people have a right to express their ideas, then perhaps we would see the role of the service provider to provide a therapeutic program as an obligation rather than an option among many.

Dr. Irene Campbell Taylor - May, 1984: Eleanor Anderson, Coordinator of Speech and Hearing, invited Dr.Taylor, a speech pathologist from Sunnybrook Hospital to lecture for two days on speech and swallowing disorders in the elderly. The topic was of real interest to us so we arranged to audio record these sessions. The response to these lectures was just astounding. Some one-hundred people came to the first day at Holland College's lecture hall.

We at EPA interpreted this response and the subsequent demand for copies of the audio tapes as an indicator of a theme or topic that we should pay some attention to. We decided to do more than that.

Gary Kapelus, D.S.P. - August, 1984: Gary, of West Park Hospital in Toronto, (presently Director of Speech and Hearing at Centennary Hospital in Scarboro, Ontario) gave the first in a series of workshops to service providers in Summerside in the latter part of the summer. His theme was that we can and should do more to enable the elderly who are victims of cardio-vascular accidents to communicate with the rest of us who are not. The enthusiastic evaluation of this workshop at a manor gave some direction to the project in the fall.

Two Workshops on Stroke - Fall, 84: Eleanor Anderson became interested in doing some workshops at the request of the staff person on the EPA project. Eleanor gave two regional workshops on the stroke and on therapies that service providers could try to improve communication with the older clients. The response was very gratifying.

We entitled the workshops **Getting Through to the Hard to Get Through to**, and the people came from hospitals, provincial manors, private facilities, and Social Services. A total of sixty-four people spent three and one-half hours learning, listening, and talking about their roles as caregivers.

Generation Fair - Nov/30 - Dec/1, 1984: A health fair which we called **The Generation Fair** was organized on the theme that services to the elderly could be developed more effectively if we brought them to the public in a shopping mall and asked people what they wanted.

Island Tel provided some very interesting keyboard-telephone hardware used by the deaf, It was a popular booth at the fair.

Symposium '85 - July: Plans to bring Gary Kapelus back for more workshops dovetailed into the planning for Symposium '85, the first annual summer institute on aging for service providers. Gary gave workshops to the participants at the symposium with a good response. He also gave a four-hour special workshop to all speech and hearing workers (twelve) in the province at the request of Eleanor Anderson. The evaluation on this event was very positive. Eleanor wrote that she wanted more.

Video on the Stroke Victim: It was at this time that Eleanor and the staff person decided that there was a need for a video-resource on the stroke as it effects older people. This video was begun and finally produced in the spring of 1986. The name **Communicating After the Stroke** - 23-minutes, color.

February 18-19, 1986: Two very popular workshops--one in Summerside, one in Souris--were put on by Eleanor Anderson on essentially the same theme: **After the Stroke.**

Speech and Hearing Brochure - May, 1986: Eleanor Anderson's division of speech and hearing designed a brochure on communication disorders in the young and old this month and chose as a cover photo a slide provided by the staff person of EPA theme.

INSIGHT - Pattern Three

When I first approached the Division of Speech and Hearing, the workload of the staff was essentially child centered. Eleanor Anderson told this staff person in our first conversation that her division could not see its way clear to become involved with the geriatric population "as pressing as their needs were."

This staff person is pleased to report that hundreds of service providers and many thousands of radio listeners (Gary Kapelus appeared on CBC radio during Symposium '85) were presented with educational events where skill was shared and attitudes about "how to get through to the hard to get through to" were challenged.

Pattern Four - Oral Care of the Elderly

The mouth is probably the last place that caregivers look when providing service to the old. Some institutions have a rudimentary oral check-list on the entrance form but, by and large, there is not much attention given to the mouth.

The Problem

Consider what life is like when your denture is loose or your front crown breaks. One is inclined to avoid public appearances until one's teeth are back to normal.

Often the retiring and reclusive elder is one who would rather not be seen in public because his teeth are a sight. Oral care for appearance as well as health of the oral cavity have not been a health care priority in planning services for the elderly.

Fall, 1984 - Kensington Team: The importance of good oral cavity maintenance became evident to the staff person of EPA as he began to work with the Kensington team--a multidisciplinary group of health care professionals. Each member of this team has his/her own educational needs and the staff person became aware of the needs of the dental practicioner as the team evolved.

After confirming with the EPA team that this might be a worthwhile direction, the staff person contacted Dr. Don Coffin of Charlottetown. Dr. Coffin was the president of the Dental Association and had been to a workshop given by Dr. Ron Ettinger of Iowa State University. Dr. Ettinger is the acclaimed geriatric dental speicalist in North America. The staff person then wrote Dr. Ettinger to explore whether he could come to PEI during Symposium /85. Dr. Ettinger wrote back that he couldn't make it.

On Dr. Coffin's recommendation, I then called Dr. Gary Jackson, the staff person at Dalhousie. Dr. Jackson was skilled in the area of oral care of the elderly and was more than enthusiastic to come to do workshops on PEI.

Symposium '85 - July 85: The staff person developed a four-hour workshop featuring Dr. Jackson during one of the symposium days at Holland College for dentists, dental assistants, and dental hygienists. The Dental Association paid all the speaker's expenses and symposium provided AV hardware, classroom space, and coffee and donuts. Twenty-two dental professional service providers attended and we were on our way to seeing another trend.

Oral Care Workshop - October, 1986: Dr. Jackson returned in October to do a full-day workshop in Maplewood Manor--a provincially owned long-term care facility of fifty beds. The staff person also involved the local dentist, Dr. Dave Crocker, and his office staff for the workshop. Dr. Crocker agreed to do follow-up visits at Maplewood manor to continue the interest in oral care of the residents. Dr. Crocker shut his practice down for the day and paid his staff to attend the workshop.

The day was marvelous--the evaluations very positive--and the impact on the facility is still being felt in the attention to the oral care of the residents.

Montague - October, 1985: Thirty-one service providers including the Director of the Division of Dentistry of the Department of Health and Sccial Services, Dr. Bob Romcke, attended this three-hour session on oral care.

Dr. Jackson returns - **November, 1985,** Holland College requested a joint workshop for the dental assistant program students and the resident care worker program.

Nov/15 - P.M. - Workshop in Dentist's Office: The staff person arranged a one-hour special workshop in the dental office of Dr. Paul McCarville. Dr. Jackson spent the hour presenting oral care, using slides and discussing drug use and its impact on the oral cavity. Zerostomia is a condition which Dr. Jackson

was explaining (dry mouth). The condition is a result, more often than not, of too many pharmaceutical remedies. The mouth dries out and teeth rot quickly or dentures won't stay in.

FOOTNOTE: Workshops "paid off" in advocacy. A few days later, Dr. McCarville met the staff person in the street and told him, with some enthusiasm, that the workshop had paid off in direct service to an older patient who had Zerostomia as a result of drug therapy. Dr. McCarville had been asked by the patient to extract most of his teeth because they were rotting. Dr. McCarville refused to do this until a conference with the man's physician could be arranged to discuss his drug therapy and its dramatic effect on the oral cavity. Now **that** is **advocacy** of the first order.

Queen Elizabeth Hospital, Nov/18: Dr. Jackson spoke on Zerostomia, drug therapy, oral care, and early identification of oral cancers.

Attitudes about Aging - Dr. Jackson's presentations from the beginning have always been centered around the attitudes of the caregiver about the older patient. Dr. Jackson always presents well on this topic.

Spring, 1986, Dental Association: The P.E.I. Dental Association with a new executive responded to the growing interest in oral care and invited Gary Jackson to present to the dentists who didn't make the Symposium '85 event.

CBC - TV Coverage: The staff person arranged for Dr. Jackson to be interviewed on Compass, CBC's evening current affairs program in Charlottetown. The viewing audience is some 30,000 people. Dr. Jackson told a story about an older woman (65 years) who had lost her husband and suffered a depression for which she was treated with drugs. Drug interactions caused Zerostomia or dry mouth to develop with the result that her dentures no longer fit. She became more depressed and exentually ended up at the manor in Halifax where Dr. Jackson works.

Letter from Viewer: As a result of the TV appearance, Dr. Jackson soon received a letter from a woman (66 years old) who was having a lot of trouble with her dentures. She didn't want to have the nerves in her jaw cut because she had seen examples and was not impressed. The letter was quite touching, and Dr. Jackson responded by putting the woman in touch with a Charlottetown dentist who could treat her more effectively than her current dentist. So getting information like this on the electronic media had a direct positive result--one that we were able to document.

INSIGHT - Pattern Four

Oral care, not heroic intervention that is expensive and usually inappropriate, is the recommended procedure in care of the elderly. Dr. Jackson returned to lecture to service providers at Symposium '86 (June 25-26).

The president-elect of the Canadian Dental Association has written the staff person to assure him that the CDA is committed to senior citizens:

> "As president-elect on the CDA, one of my main concerns is for our senior citizens and their concerns. Many have not had access to good dental care and hopefully programs like yours can help to enhance the 'quality of life' for our seniors."*

To enhance the quality of life of older people was the primary goal of the EPA project and the staff person feels gratified that leading health care professionals like Dr. Robertson see a connection between educational events and an enhancement of the quality of life of older people.

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*Dr. John R. Robertson, March 15, 1986.

Pattern Five - Symposia

"From little acorns...." The pattern here exists in the development of a summer symposium in PEI on aging for service providers from its inception to the latest future projection of a national conference in 1988 by the chairman of Applied Arts at Holland College.

Summer - 1984 (first step) - the idea of a summer institute was born and 'fleshed out' by staff with assistance from Ann Goldblatt, a summer practicum student from Toronto. The GR person arranged for a one and one-half day lecture series with Dr. Gilbert Rosenberg and Patricia Conrad of Mount Saint Vincent University on aging issues. The local wisdom was that 'no one on PEI would attend lectures in the summer.'

We gambled and acquired a financial partner in the LNA Association. We contracted with the speakers and planned an early July series. The response was very positive. Full house attendance--we made a surplus and were able to send the speaker a few more dollars for all his work.

Foundation Laid - Buoyed up by our success, we began to plan a summer, 1985, event of larger proportions to include physicians, dentists, speech therapists as well as allied health professionals. We collaborated with Dalhousie University, the PEI Dental Assoc., and Holland College to develop Symposium '85 - A Conference for Service Providers to the Elderly. In all, some 220 service providers attended sessions in Charlottetown. Forty-five of these people came from other provinces in the Atlantic region.

Symposium '86 - With about $1400 surplus from Symposium '85, we planned Symposium '86 and contracted Holland College once more to plough the surplus into a Symposium '87.

Symposium '87 - Larry MacPherson, the Chairman of Applied Arts at Holland College,in a memo dated May/14/86 indicates his resolve to plan Symposium '87 as an Atlantic event and Symposium '88 as a national conference. All of this started with a lecture series in the first few months of the EPA project. The risk was worth the taking.

TOOLS AND MODELS

Tools:

A) Resource Library - The project created a resource library with eighteen headings and many hundreds of printed articles on topics ranging from social welfare to attitude measurement.

Health care professionals have used the resource library in their literature searches for courses at UPEI and in courses towards a gerontology certificate at Mount Saint Vincent University in Halifax.

The resource library was one of the objectives of the project that we tackled first in the early months of 1984. The process of clarifying headings and topic areas for the easy categorization of articles, pamphlets and books was a rather fruitful one for the team of Janet Yuill, Frances Piercey, and Kevin Moynihan.

B) Audio Tapes - The Training For Service Providers portion produced twenty-seven different audio tape (cassette C-90) recordings of lectures at various educational events organized by the project. The topics range from drug interactions in the elderly to physiology of aging to foot care.

We have provided copies of these tapes or selections from the twenty-seven master tapes to the regional offices of the Home Care and Support Division on permanent loan. These tapes are used by home care nurses, homemakers, and community workers in their car tape machines while on the road--a sort of 'mobile inservice.'

C) Two Radio Documentaries - The Gerontology Resource Person wrote two radio documentaries which were produced and broadcast (twice) by CBC - Charlottetown.

The Topics: i) DRUGS AND THE ELDERLY is a 16-minute documentary that explores drug use by the elderly and presents a creative alternative, i.e., good diet, drug reduction, and a serious commitment by the health care professionals involved to guard against over-medication of the elderly.

ii) THE NATURAL CAREGIVER is an 18-minute documentary that explores the role of caring for aging parents. The stresses as well as the positive side of this experience are drawn out in interviews with caregivers, social scientists, and professional service providers.

D) Five Video Tapes - 1984 - i) CAN'T YOU GIVE 'EM SOMETHING is a 16-minute video documentaty shot on location at Summerset Manor in Summerside, P.E.I. It explores the drug reduction program initiated there in 1978. The program has been successful in reducing the amount of drugs consumed by residents up to fifty percent. The elements that contributed to such results are presented. The physician, the resident, the nurse, and the administrator all play a role, and we hear from all these people in the course of the video. The key person is, of course, Kathleen Corr, a former resident of the manor who now lives on her own. She tells her own story.

1985 - ii): IN A LAND OF PLENTY is a 12-minute documentary video exploring the major causes of mal-nutrition in the elderly who live alone. The effect of too many prescription and over-the-counter drugs; the tea and toast syndrome; myths about binding foods; and the relationship of milk products to preventive health care are explored.

The role of meals-on-wheels is presented as an alternative to institutionalized care. We travel to Alberton, PEI, where a successful program is in place and meet some of the people responsible.

This documentary, shot on location, presents some of the preventive health care concerns of those who care for the community-based elderly. It is designed as an educational tool for these same service providers as well as the general public to help them to understand how older people living alone can be mal-nourished in a LAND OF PLENTY.

1985 - iii): NEW WRINKLES ON OLD ATTITUDES is the Symposium '85 keynote address given by Dr. George Merry of St. Mary's of the Lake Hospital in Kingston, Ontario. The length is 30 minutes but it moves along assisted by Dr. Merry's slides--a good mixture of serious data on aging and humorous examples of negative attitudes found in the media and comic strips.

1986 - iv): AFTER THE STROKE is a 25-minute video that presents four older people who have suffered CVA's/strokes along with a diagnosis and a therapy. A speech pathologist works with each patient and demonstrates the various therapies and techniques designed to help the person to recover the ability to communicate effectively once more.

1986 - v): THE PLACE TO BE is a twenty-five minute documentary exploring some of the middle ground between the nursing home and the family home for older persons. The options are presented in three forms: the manor or nursing home; the community care facility (that provides no nursing care); and the private home or apartment with some community support.

Within these three large options, there are many variations and the people who appear in this film explain them. A bachelor who used to farm alone found that preparing meals was a bother so he lives in a group-style home in Charlottetown. A former post-mistress who lives alone in a huge family home explains why it's important to her to stay in her community--'never a nursing home,' she says.

The individual heroism of independent people who live in the dwellings of their own choice comes through in this video. And the importance of that choice is the message that comes through the interviews and profiles.

Models:

A) Seniors' Line - CBC Radio

SENIORS' LINE
ON
ISLAND AFTERNOON
Tuesdays 4:30-5:00
Kensington's Gertrude Pendergast joins host George MacNabb for a lively discussion of subjects of special interest to senior citizens. Topics including planning for retirement, coping with living alone, health and recreation, and money management for seniors are scheduled for discussion on this Open Line.
Listeners can take part by calling 892-3591 on Tuesdays between 4:30-5:00 pm. (Call collect)
CBCT RADIO
96.9 FM

Seniors' Line was a weekly current affairs program broadcast across PEI on the CBC-CBLT service. The program began as an idea planted in the mind of the executive producer of radio at CBC by the Gerontology Resource Person (the GRP had worked as a freelance journalist at CBC before joining the EPA team).

The executive producer of radio passed on the idea to the producer of 'Island Afternoon,' the 4-6 p.m. current affairs program and he called the GRP and asked for a meeting to explore the idea.

Since the CBC people felt ownership of the idea for a weekly spot devoted to airing issues of concern to seniors, the collaboration was very much a consultative one. The first show (one-half hour) ran as a guest interview and 'phone-in' on June 21, 1984. And every Tuesday thereafter until that producer, Doug Hughes, left the Charlottetown, CBC for Vancouver in the fall of 1985.

The Gerontology Resource Person provided the program ideas, the people to be interviewed and background notes--along with questions to the CBC. This arrangement continued for several months until the producer began to feel that he could fathom out the issues and people himself. In the spring of 1985, the GRP reported in his monthly reports that the CBC staff people seemed to be becoming advocates on behalf of older Islanders. They were able to identify some of the issues and people most pertinent to seniors concerns.

CBC Radio changes its style: In the summer of 1985, the CBC began to change its programming to appeal to a young urban professional listener. Seniors' Line was in jeopardy. Doug Hughes, the producer of Island Afternoon, returned from an orientation session in Toronto to report that programming was to be geared to the 'Yuppie' audience. He said this with regret and subsequently proceeded to try to convince the CBC Ch'town executive producer and station manager to resist the national trend and keep a multi-generational audience in mind.

The Gerontology Resource Person assisted with some documentation to reinforce the importance of Seniors' Line and reminded the producer that the 4 to 5 o'clock spot on Tuesdays when Seniors' Line was heard received the highest audience response rating in the last ratings check. Nevertheless, CBC went Yuppie and Seniors' Line had to be consumed into the dominant style. The producer assured the staff person of EPA that seniors' issues would still be aired but not under the Seniors' Line banner. As time went on, the issues of concern to older Islanders were aired but the loss of Seniors' Line was still felt by some older residents of P.E.I.

INSIGHT

CBC Radio has a mandate to reflect Canadians back to themselves and in PEI, 12.2 % (1981 census) of 'themselves' is over the age of sixty-five years. Therefore Seniors' Line was a natural. This kind of service (Seniors' Line) fits into the mandate of current affairs radio at CBC and it can be assumed that anywhere in Canada the CBC would respond to such an invitation.

It seems fitting that we had the opportunity to demonstrate how compatible the mandates of provincial and federal agencies can be when they concern the health and welfare of citizens. The funding came from an agency whose name reflects this concern and the model was realized by an agency whose concern is reflections that are accurate.

B) Community School

Continuing adult education is alive and well and living in Prince Edward Island and called Community School. Based on the Danish Folk School model, community school was developed in 1965 as part of the 'Island way of life' renaissance which had as its goal to develop rural PEI as a viable alternative to urbanization.

Community School is a skills exchange operated for ten weeks from January to March where local experts teach local people anything from market gardening to firearm safety.

The Gerontology Resource Person developed a course on aging for Kensington Community School. Eleven people signed up and for six out of the usual ten weeks spent Wednesday evenings discussing aging with invited guests and the GRP. The result of this involvement was the development of a manual for such community-based settings. The writing of the manual took several weeks in the summer and fall of 1985, and a prototype was ready for Community School 1986.

Two animators--one in Kensington and one in Vernon River--piloted the manual and found it a helpful guide to their own courses on aging. Both these volunteers were retired public health nurses, but the manual was written for the lay person who doesn't have a health-related background.

The Training Manual on Aging: The manual is completed and can be 'exported' to other regions of Canada. It contains directions, audio visual materials and methods for evaluating learning in eight sessions. Each session is divided into two topic areas with recommended media and a list of typical resource people whom the animator can call upon.

The language and style of the forty-page manual make it eminently usable by the concerned advocate who has no training in health care. 'The Training Manual on Aging' is a part of the curriculum component of the final report of the EPA program.

C) Cable Television Service - Two-Way TV

In January of 1986, the Gerontology Resource Person, in collaboration with the Family Life Coordinator of the Division of Nursing developed three topics and identified six resource people and a moderator for three 'electronic workshops.'

The GRP adapted a two-way TV model he had seen in Quebec in the early seventies and demonstrated its usefulness in PEI. The winter winds keep people at home in most of PEI on certain January, February, and March evenings; therefore, the idea of a cable TV workshop would be very applicable. People could stay home or go to a neighbors' home with a small group and still take part in a workshop.

Two-way TV: Television is a passive, one-way medium. One telecasts or cable-casts information and can only speculate on the receivers of the message. Two-way TV, as it was demonstrated in Summerside by the EPA project is a method of using the telephone and television to establish a dialogue.

The Model: Small groups were asked to participate by watching Cable Channel 7 on Tuesday evening at 7:30 to 8:30 p.m. In the TV studio, we had a moderator and two guests. The moderator introduced the guests and then a film. When the film was over--7:25 or so--the moderator animated a discussion with the guests and then turned to the viewing audience to invite telephone questions. The questions came in, we wrote them on slips of paper, and handed them to the moderator who presented them to the guests.

The groups were: a church youth group and their parents; four public health nurses; residents of a manor, and two families watching in their own homes.

Night One: The topics, guests, and media - SEXUALITY THROUGH THE YEARS: doctor and a nurse-educator; filmstrip: "Sexuality Through the Life Cycle" (permission granted by Sunburst Audio Visuals in New York).

CARING FOR AGING PARENTS: Community Support Worker (with Home Care and Support); and natural caregiver whose parents stayed with her in her home for thirteen years; Video: On the Aging of Parents; (permission granted by Lutheran Centre on Aging, Washington State University).

TOUCHING: Social worker and hair stylist; Video: "The Touch Film" (permission granted by the producer in Chicago).

*One should always clear copyright or ask for permission to use film on cable TV since it is considered under the copyright act to be an infringement to do so without permission.

The evaluations were very positive with a letter of commendation from the pastor of the church group who participated. This model and many more are available in a publication by UNESCO, Paris, 1975, entitled "Access."

The Gerontology Resource Person was one of the researcher-authors of this United Nations probe into creative models for continuing education in Canada.

D) Summer Symposium '85 - '86 - '87

In collaboration with Holland College, the Island Community College of Applied Arts and Sciences, the EPA project developed the idea of a summer symposium in the fall of 1984.

The president of Holland College, Dr. Donald Glendenning, and the principal, Davida Stewart came to a meeting with Kevin Moynihan, Gerontology Resource Person, and Janet Yuill, the manager of the project. At the meeting, Dr. Glendenning was very enthusiastic about Holland College as the locale for a summer conference for service providers to the elderly. The resource person took the positive response to be a sign of good faith on the part of the college and proceeded to organize a summer symposium.

The collaboration of the Continuing Medical Education Department of Dalhousie Medical School was sought and contracted by the GRP. Holland College and the Department of Health and Social Services agreed to share the responsibilities and the symposium needed only content planning.

After conferring with a planning committee, the resource person laid out the schedule and speakers for Symposium '85 - a conference for service providers to the elderly. July was chosen and the response was very gratifying.

In all, some two hundred and twenty health care professionals, doctors, dentists, nurses, speech therapists, occupational therapists attended. The evaluations were very positive and the planning for Symposium '86 was underway.

The surplus of some $1300 was used for planning Symposium '86 and the contracts again stipulated that all surplus would be put towards planning Symposium '87.

The idea of a multi-levelled, multi-disciplinary symposium in the summer on PEI was a natural. In the first meeting with Dr. Glendenning, he used the phrase, 'Banff of the East' referring to the role of Holland College as a host and site of summer conferences in this area. It sounded to us like a bit of a dream, but the dream has begun to shape and symposium is gaining a degree of permanence that we could only imagine in 1984.

RESULTS

Number of Workshops:

There were forty-seven separate workshops on a variety of gerontological topics. Of these forty-seven, two are major symposia but they are counted as two single events.

> If Symposium '85 and '86 were to be counted as individual workshops, they would augment the total by thirty-eight separate events.

Not included in the statistics above are two Generation Fairs, one in Charlottetown in Dec/84 and one in Nov/85 in Summerside. There is no way to estimate the numbers of people who stopped while shopping at the two largest shopping malls on PEI to inquire about home care supports or meals on wheels or any number of services--non-governmental as well as governmental--for seniors in the community.

The following are some hard statistics that give a quantitative measure of the EPA project:

Topics of Workshops	Number of Workshops
Attitudes on Aging	11
Death and Dying	2
Dependency/Independence	3
Drugs and the Elderly	3
Foot Care	8
Natural Caregivers	5
Oral Care/Mouth Care	4
Pastoral - Church Persons	2
Physiology/Sexuality	4
Speech and Hearing/Stroke	5
	47

Symposium '85 (July)

Topics of Workshops	Number of Workshops
Alzheimer's Disease	1
Attitudes	2
Dental	1
Drugs and Drug Interactions	3
Foot Care	2
Housing	1
Legal	1
Osteoporosis	2
Physiology of Aging	2
Speech and Stroke	3
Total number of workshops	18

Symposium '86 (June)

Adapting Enviroment	2
Attitude	2
Advocacy	1
Drugs and Drug Interactions	3
Foot Care	5
Nutrition	3
Oral Care	2
Trends in Care	2
Total number of workshops	20

84/85 Service Providers served	546
85/86 Service Providers served	997
86/1st quarter: Service Providers served	323

COSTS

1. Dollars paid out of the EPA budget for educational events.

   Apr/01/84 to Mar/31/85 ..... $ 1,489.00

   Dollars contributed by collaborating organizations and individuals in same period 1,031.00

2. Dollars paid out of EPA budget for educational events.

   Apr/01/85 to Mar/31/86 ..... 1,070.00

   Dollars contributed by collaborating organizations and individuals in same period 12,711.00

3. Dollars contributed by collaborating organizations and individuals in 1st quarter of 1986 ..... (approximately) 9,000.00

DISCUSSION

Measurable Changes in Service Providers

Early in the project, we struggled with the question of how to demonstrate attitude change in service providers to the elderly. The Gerontology Resource Person (GRP) consulted with Dr. Sol Feldstein, clinical psychologist at Queen Elizabeth Hospital in Ch'town. The key to measuring change seemed to be in the interpretation of the responses to the attitude change scales which were available to the EPA staff person.

In August, 1984, the research into how to go about measuring the change in attitudes began. The GRP contacted David J. Mangen, the editor of 'Research Instruments in Social Gerontology' and inquired about tests such as the Tuckman-Lorge; Rosencranz-McNevin measure which appeared in his book. Mr. Mangen wrote back that the abstracts were available to the reader and that the actual tests were 'in the back of the book.'

The Problem: Using these mental measuring tools with some degree of integrity and accuracy appeared to be beyond the scope of the staff of the EPA project. The GRP and the coordinator (Janet Yuill) of the project conferred with the funding agency and together it was decided to use a less formal instrument but one that would allow the project to respond to the ecucational needs of the service provider.

The Solution: Two Parts -

i) The GR person proceeded to use the Palmore, 'Facts on Aging Quiz' as a component in workshops to assist the participants in clarifying their own attitudes about aging.

ii) Each workshop participant would fill out a written evaluation from which contained questions like:

a) Will you change anything at home or at your workplace as a result of what you learned here? Explain.

b) Has this workshop changed any of your attitudes about old people? Explain.

c) Did Symposium '85 help you to clarify your own attitudes about aging? Please explain.

d) Do you feel differently about older people after the workshop? Explain.

The 1200 or so written evaluations that are in the files of this project contain numerous testimonial accounts of how new information or dynamic media or special resource people helped the participant clarify a strongly held attitude about aging and old people. Some report that they intended to 'change things at work' when they returned. Some reported that they would deal differently with their clients now that 'I understand what's happening in their lives.' The written evaluations are a testimonial to attitude change and, at times, to change in behavior which would follow.

Behavioral Change

The acid test of attitude change is, of course, a change in behavior of service providers toward their older clients. We have many hand written evaluations that indicate the intention to be more understanding to and to be more empathetic with the older person.

We can also cite the examples of change like the dentist in Kensington who changed his approach to care of the elderly as a result of a workshop by Dr. Gary Jackson; the Speech and Hearing Division of the Health and Social Services Dept. that went from very little involvement with the elderly to choosing 'Communication Disorders of the Elderly' as the theme for its May, 1986, campaign; to the meals on wheels coordinator who decided at a foot care workshop to become coordinator and to advocate for such a service in Kinsington, PEI.

Institutional Change

Dalhousie University Medical School - In 1984, the GR person negotiated with the Continuing Medical Education Department of Dalhousie to attract their participation in Symposium '85.

Over the year, the enthusiasm for geriatric topics became more evident. Some thirty-three physicians attended what Dalhousie entitled 'A Geriatric Short Course' at Holland College as part of Symposium '85. In 1986, Dalhousie CME office was planning a major geriatric event of its own for the June/July period.

Holland College - most dramatic

Holland College has already begun to make plans for expanding Symposium--a conference for service providers to the elderly into a national event. All this collaboration began in the summer of 1984 with the EPA project's first summer lecturer featuring Dr. Gilbert Rosenberg on drugs and drug interactions. Symposium is one more institutional change that is in place because of EPA.

Requests for Service and Products - as indicator of impact

Another indicator of a positive impact on the service provider population is the request file for 1984 and 1985. Some examples from the 1984 file which contain some twenty-two separate entries:

June 11, 1984 - a request from Ronald Langille, sales rep for VS Vitamins Corp, for a copy of 'Can't You Give 'em Something,' a documentary video we produced ondrug reduction in one of the provincial manors.

Sept/84 - a request for a series of workshops to be given to visiting homemakers by the coordinator of that service.

- a request for copies of the Rosenberg lectures on audio-cassette from a provincial manor for the purpose of staff education.

Oct/84 - a request for a presentation to a christian fellowship evening at Kensington United Church -- 40 people attended.

Nov/84 - a request to identify some good 16mm film for a senior citizen club in Souris, PEI.

- St. Georges--workshop for natural caregivers in a small rural community. One woman , who was caring for her husbands' parents had approached us for some help.

Dec/84 - a request from Mr. Stephen Dennis, administrator of a large private long-term care facility, for an information session on ideas for staff inservice in the area of key issues in aging.

Requests: 1985 - March, 1986 -

There were thirty-one requests for consultation, products, and speaker engagements in this time period. Typical of the requests were the following:

Jan/85 - James Vanden Bosch, the Chicago-based producer of 'Caring for Aging Parents' requested a copy of 'Can't you give 'em Something.'

May/85 - Stella Brennan, chairperson of the provincial CWL requested a presentation on aging at their annual meeting (about 100 women attended).

July/85 - request for information on aging from Mary Reeves, a participant at Symposium '85. I directed her into our resource library.

June/85 - Shirley Campbell, Health Education Officer, Dept. of Health, Nova Scotia, requested 'Can't You Give 'em Something' and 'In a Land of Plenty.'

July/85 - CBC Television requested an interview with the Gerontology Resource Person on an extended news item they did on drug reduction.

Aug/85 - Dr. Douglas Graham, Medical Advisor, B.C. Ministry of Health asked for a copy of 'Cant you Give 'em Something.'

Sept/85 - Doug Hughes, producer of Island Afternoon, CBC Radio, requested statistical information on maintaining CBC's interest in aging population.

Oct/85 - Dr. Robert Romcke, Director of Dental Division, requested advice on media coverage of dental workshop.

Nov/85 - Dalhousie - Dept. of Continuing Dental Education requested consultation on design of research tools around Dr. Jackson's PEI workshop.

- Anglican Church--St. Paul's in Ch'town, requested the GRP* to speak on aging and visitation to the elderly by members of their church group.

Dec/85 - St. John Ambulance requested the GRP to give one of ten evenings to their respite care workers in training.

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*GRP = Gerontology Resource Person.

Achievement: two types of change

There are two types of change created by EPA Training for Service Providers.

1. Personal or Individual Change - is based on the goals of the project and that was to help to create a positive attitude about aging and the elderly in the people who provide services to them.

Based on the manyhundreds of testimonials to change that exist in the written evaluations from all the workshops--45, plus two major symposia--one could conclude that for many of the nearly 1500 people who attended the workshops over the length of the project that attitudes were changed. Attitudes were changed because of new information, because of co-worker pressure on the job, and because of the inspiring example set by the many committed professionals who toiled for us at our events.

2. Institutional Change - no less permanent are the changes we witness in the schools, colleges, and professional associations with whom we have worked.

Dalhousie Medical School - Department of Continuing Medical Education, offered a geriatric short course for physicians that would not have been offered in PEI without EPA.

Dalhousie School of Dentistry - Dept. of Continuing Dental Education lent Dr. Gary Jackson to PEI for numerous workshops and educational consultations; he began to develop a project proposal for measuring attitude change in long-term care institutions after oral care inservice.

Division of Speech and Hearing - Dept. of Health and Social Services moved from a limited involvement in geriatric care to requesting a video-teaching tool on stroke therapy for older clients as well as declaring the focus of May/86 speech and hearing month to be communication disorders of older persons. Posters and booklets focus in on the older person's potential for recovery.

Holland College - Dept. of Applied Arts is planning for 1987 and 1988 symposia on aging based on the EPA models 1985/86. The chairman wrote in May/86 that he felt that Symposium '87 should be an Atlantic event and '88 should be national.

Dental Assistant Program - - of this same department has indicated its intention to hire Dr. Gary Jackson for the month of June/87 to instruct dental assistants in geriatric oral care. EPA was the broker in this transaction.

Division of Aging and Extended Care - Summerset Manor, a provincial long-term care facility of 120 beds and a day program requested the GR person to join its staff development team to plan educational events for the future. This is an interesting turn of events since the EPA project was first proposed by the Division of Aging in 1982.

CBC RADIO had established Seniors' Line (over 50 weekly broadcasts) as a permanent service for the purpose of exploring issues concerning older Islanders. The national office changed the direction to the afternoon show however and Seniors' Line was 'submerged' in the general current affairs programing of the week. The decision was not Charlottetown's but Toronto's.

THE NATURAL CAREGIVER

Natural caregivers, so called because they provide the life support system of the older person 'naturally.' They are family, neighbors, and friends. In the literature, these caregivers are also called primary caregivers. By far the majority of caregivers to the elderly in PEI would fall into this natural or primary category. Yet they were not identified as part of the target group for the EPA project.

Early in the program, we decided to address this question. We recommended to the Health Promotion Directorate that we include the natural caregiver in our workshop target group. We received permission to change or expand our focus to do this and proceeded to develop special workshops to provide educational opportunities for this special group of caregivers.

Seniors' Line - for natural caregivers

The CBC radio show for which we provided people, ideas, and script explored the stresses of the family caring for the aging parents in numerous ways over the fifty or so broadcasts.

CBC Radio Documentary - Feb/85

The GR person wrote a 15-minute radio documentary for CBC radio called 'The Natural Caregivers' which was aired on Feb/5.

Community School Manual - for natural caregivers

The community school manual, 'The Training Manual on Aging,' complsed of eight sessions (two topics per session) was written especially for the non-professional service provider who wants to learn more about aging and older people.

Workshops in French - for natural caregivers

The Gerontology Resource Person, in collaboration with a public health nurse in the Evangeline area developed four evening workshops in the Spring of 1985 for the natural caregiver or donneurs de soins. The workshops were in french with resource people from the local region and French and English media.

Death and Dying - March 28, 1985: the first workshop on Death and Dying was very well attended (20 women came).

April 25, 1985 - Independence - Dependence: the second, we had five participants.

May 2 - Myths and Realities of Aging was the topic and four people came. The fourth topic was **Physical Needs of the Elderly:** we had only one person come.

What were we doing wrong? The greater majority of older people in this francophone region of PEI were being cared for by family and friends. These were the people we felt needed these workshops and this opportunity to ventilate and perhaps form a support group. The people weren't coming out. Jeannitta Bernard, the public health nurse and acadian folk singer with whom the Gerontology Resource Person worked on this series, was as much in the dark as anyone about the dwindling participation.

The Problem: two explanations - we analyzed the poor attendance and came up with two basic explanations. **(i)** 'the natural caregiver' was not yet a role in the community that had been identified as a special service over and above what one does 'naturally' out of obligation for one's parents or in-laws. In other words, the role has not been separated from other family obligations and, as a result, the caregiver doesn't know she is a caregiver. The question of providing educational and training sessions for caregivers who have no consciousness of this role is, necessarily, a problem.

There is need for some preliminary work in 'consciousness raising' about this role to be followed by development of educational resources to serve these caregivers.

(ii) Scheduling is everything. We had arranged newspaper and radio promotion on the workshops but had not considered the other events that were also planned for the same night. One week there was a mission at the local church; another, a major bingo.

There are sixty or so organizations in this region of the province and only four nights out of a week for meetings. These seem like lame excuses for having dwindling returns on workshops, but it could have been a factor.

INSIGHT

The major contributing factor to the diminishing numbers at workshops is still the lack of consciousness of the role of the primary or natural caregiver. Workshops cannot be answers to questions not yet asked. And this is what we were. The first thing to do is to assist the caregiver to ask the question: How can I be a better caregiver to my aunt, or mother-in-law? Then comes the answer.

CONCLUDING STATEMENT

Three Key Issues:

Over the course of the two and one-half years, it became evident that, in terms of service delivery to the elderly, there were three areas of concern. The first was drugs and their impact on older people who take them; the second was nutrition, and the third was housing.

The Gerontology Resource Person developed resources (radio documentaries, video documentaries, articles and a chapter in a high school text book) and organized workshops on these three topics. Drugs, nutrition, and housing are topics out of which most issues for the care of the elderly come. They proved to be very fruitful points of departure for organizing natural caregiver seminars as well as service provider training sessions.

Priority for the Future:

In Prince Edward Island, two and one-half years of workshops, radio, TV, and newspaper exposure has had an impact on the service provider population. However significant Educational Programs on Aging have been, there is still a whole group of people who require educational support of the EPA kind.

These people are the natural caregivers, the families and friends and neighbors of older people who provide housing, supervision, activities, nutrition counseling, etc. But most of all, they provide support and love. Their primary motivation is one that is not terribly complex but what it lacks in complexity, it makes up for in patience, understanding, and flexibility.

The natural or primary caregiver should be supported by government dollars, personnel, and most importantly, by programs that will help to educate about aging. If the family is informed about the potential of older people to remain in the community; if the family is aware of the options in housing and home care; and if the family understands that aging is a natural process and not a disease, with all that this statement implies, then older people would remain as dynamic and active members of the families that they started and nurtured. And elders would assume their rightful positions in the family not as vulnerables but as venerables.

Whatever the motivation for ensuring that this happen, enlightened self-interest, charity, or justice, the result will be an Island where all of us will want to grow old together "for the best is yet to come."

APPENDIX

Central School
for
Nursing Assistants
3 Brighton Road
Charlottetown
Prince Edward Island
C1A 8T6

July 15, 1986

Mr. Kevin Monaghan
Coordinator - Education Program on Aging
Dept. of Health and Social Services
P.O. Box 2000
Charlottetown, P. E. I.
C1A 7N8

Dear Kevin:

I was able to attend both Symposium '85 and Symposium '86, and I feel your efforts in organizing these seminars deserve some acknowledgement.

Teaching student nursing assistants requires keeping updated not just on theory, attitudes and new trends - but on hands-on information. These Symposiums gave a blend of all of these areas and that makes them useful for many levels of care-givers, as well as families caring for aging parents, or in/fact the elderly themselves.

Sometimes it's impossible and always it's difficult to measure the impact of such events such as the Symposium, so I would like to share a couple of indicators from my own perspective. The key-note speaker(s) each year brought a universal perspective that always helps Islanders feel less isolated in coping with our ever-increasing population of elderly people. I personally found this helpful, and I frantically took notes that I can use in my teaching. This year Patricia Moore's Advocacy message triggered off the advocate in me, and I've already written to the Dental Association on P.E.I. to protest the lack of accessibility to dentists' offices on P.E.I. for anyone with mobility problems. I feel everyone hearing her will be more aware of ageism.

I am in an unique position of going to several institutions with student nursing assistants. Those areas that send staff to such workshops as the Symposiums tend to give care incorporating new trends rather than "old faithfuls" now known to be obsolete. A concrete example is cutting toenails following bathing or using "lethal weapons", to quote Dr. Merry, to cut toenails. Beach Grove Home changed their nail care routine as a direct result of new

...2

information but other institutions not accessing this information still cut nails using "high-risk" methods. In our nursing assistant program there are 30 new people entering into the workforce on P.E.I. who this year will be more updated on such subjects as foot care and oral care as a direct result of this workshop. Also because all the information I collected during the Symposium is shared with my colleagues, 5 instructors have this new information and each is in a unique position to influence care-givers in the institutions where we take students for clinical experience.

Finally, the Symposium gives staff from different facilities a chance to share ideas of what each does well. I think it's the only chance for staff, other than Directors of Nursing or Administrators, to do this. At breaks I heard several discussions to indicate this sharing - i.e. a nurse from a private home asking a nurse in one of the government facilities if she could visit to pick up ideas on drug reduction program. It makes me feel very bad when good ideas in one facility aren't incorporated into other areas. Since the philosophy of care is consistent throughout, we need many more opportunities for communication between facilities. Symposium '86 used this arena to educate others on the new Home Care Program, and I felt this was very helpful, and the other participants I shared that with agreed with me.

I couldn't stay on Friday morning for the evaluation session. I hope these comments serve as my feedback on Symposium '86.

Yours truly,

Emily Bryant

Emily Bryant, R.N.

EB/rm

SECTION II

CURRICULUM

CONTENTS

	Page
A PROFILE	1
Assumption One	1
Assumption Two	2
Assumption Three	2
Natural Caregivers	2
WORKSHOP MODELS	4
Attitudes about Aging	4
Drugs and the Elderly	7
THE MEDIA	8
Radio: Seniors' Line	8
T.V.	10
Newspaper	10
Educational Videos	11

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A. EDUCATIONAL PROGRAMS ON AGING - TRAINING FOR SERVICE PROVIDERS

A P R O F I L E

Background

This half of the project saw a variety of educational events, workshops, conferences, radio documentaries, video packages, audio tapes, and articles written for the purpose of assisting service providers to the elderly to clarify and improve their attitudes about aging.

The assumption has been that if the service provider approaches the older client/patient with a more positive attitude about aging, then the quality of the care would be improved. A more positive and understanding service provider/caregiver will offer a higher level of care than a service provider who might view aging as a disease and the older person as having very little potential.

In the original proposal (dated April, 1982), the goal for the EPA Project was stated this way:

> "The goal of the proposed Educational Programs on Aging Project is to improve people's knowledge/attitudes about the elderly, about the aging process, and about the influence of good health and positive attitudes on aging." P i.

Assumptions

The Training for Service Providers component began by making some assumptions about "the service provider."

Assumption ONE: the service provider would be, normally, resistant to attitude change if invited to attend an "attitude change" educational event. This is normal social psychology.

Assumption TWO: The service provider, professional or volunteer, is a practical, hands-on person who views educational events as opportunities to learn how to be a better nurse, etc. Therefore, the educational event should have skills as a major component.

Assumption THREE: Ideas, good as they are, don't change people's attitudes very effectively. A more potent mix of those same good ideas evident in the life and work of peers is probably more effective. Therefore, we concluded that the resource people for the workshops, audio visual material, and conferences have to be role-models as well as well-informed professionals.

Workshops are Planned

With these three assumptions clarified, we proceeded to plan and implement workshops and material that would help the service provider to acquire more positive attitudes about aging and the older client.

Natural Caregivers are Included

As we began, we quickly discovered that we had not included a whole group of caregivers who receive neither salary nor recognition for the services they render to the elderly. These people are the families and neighbors of older persons who live in the community. The primary or natural caregiver assists the older person to remain in the community in a myriad of ways that range from providing shelter and support to twenty-four hour care.

These unsung service providers we included in our target group; and with some modest success, we managed to attract them to workshops on foot care, nutrition, drug therapy, and death and dying.

There is, no doubt, the basis for a whole project in serving the educational and psychological needs of the natural caregiver in Prince Edward Island.

B. WORKSHOPS

1. Attitudes About Aging

Educational Objective(s):

a) To help service providers to clarify their own attitudes about the aging process and the older client.

b) To present the potential of older people to the service provider.

Resource People:

a) Allied health type--R.N., O.T., etc., Gerontology Resource person, or concerned advocate.

Resource Material:

a) Erdman Palmore's FACTS ON AGING QUIZ. Twenty-five questions, Canadian updated version in Canadian Journal on Aging, Vol 3 - No 4, p-165ff.

b) Role play material, HELP THE AGED

c) The TRAINING MANUAL ON AGING. (Section III)

d) GENERATIONS: film, 13 minute, color, 16 mm, distributed by International Tele-film, Toronto, ON.

e) SUCCESSFUL AGING, THE MYTHS, REALITIES, AND FUTURE OF AGING IN CANADA, Dr. Mark Novak, Penguin, 1985.

What to Do:

a) Use the aging quiz as a starter, then supply the answers and the data that support the answers.

b) Use the film--for a very positive statement on aging--Discuss.

c) Try role playing and discussion (see: Training Manual, for more details).

e) Check Dr. Mark Novak's book, SUCCESSFUL AGING, p-18-25, on myths and realities.

Facts (where to get them): (Excerpted from SUCCESSFUL AGING)*

a) *Housing - Older people today value their independence more than anything else. They want to stay our of institutions, they don't want to live with their children and they prefer to live alone rather than depend on anyone. From 1971 to 1976, the number of older people heading their own households went up by almost 4% a year, even though the older population went up only 3% a year. 'The desire to remain independent in a home of one's own choice,' Professor Alan Backley told a 1980 conference at the University of Toronto, 'is overwhelming.'*

*Today, three-fifths of people 65 - 74 years old live in private households with their spouses or unmarried children. Even past the age of 75, 65% of men live in these kinds of settings. Because of widowhood, women tend to live alone or in collective dwellings. Still, only 9% of people over 65 live in any kind of 'collective dwelling,'--a hotel, nursing home, rooming house, lodge, motel, or institution. pp 96 - 97.**

b) *Income - Professor David Cheal, sociologist at the University of Winnipeg, has spent three years studying family gift-giving patterns. Most people, he says, assume that the very old (along with the very young) get the most help from others. This may be true when it comes to government pensions or health services, but it's not true within the family.*

Cheal went to the Statistics Canada Consumer Expenditure Survey. He found that, in the family, money flows from older to younger people throughout the life cycle. The young, he found, get more from middle-aged and older people, but 'adult children received more tangible aid from their parents that they gave.' Even as income drops in old age, gift-giving only drops off slightly. 'The elderly in Canada in fact incur relatively large financial loses in their interpersonal transactions.'

Income, however, is not the only element in the typical older person's finances. As Professor Cheal shows, many older people have savings that add to their income. He found, for instance, that while avarage total wealth decreased after age 64, liquid assets, like savings, did not. They reached their peak in old age, and older people tended to give this money away. 'Many old people are relatively better off than earlier analysis had suggested...[and] many of the aged in North America have significant economic resources available for their own use and for transfer to others.'

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*See page 4 - Section: Resource Materials (e)

*Older people also have other resources besides savings. The Economic Council of Canada reports that in 1971, for instance, 75% of older men and 55% of older women owned their own homes, often free of mortgage. Those who live in apartments often receive rent subsidies. Older people also get discounts on travel and theatre tickets, and most communities offer free recreation programs for seniors. Taking this all together, researchers Stone and MacLean say, would raise older people' total average income by at least 30%, and event this probably underestimates total income: other sources of income include non-cash benefits like subsidized health care costs and housekeeping services. Pp 132-133**

c) ***Institutions*** *- In Canada, 8.4 percent of the aged are in nursing homes, chronic bed hospitals, and homes for the aged.*[1]

**See page 4 - section: Resource Materials (e)

[1](Schwenger and Gross), AGING IN CANADA, Edited by Victor Marshall, published by Fitzhenry & Whiteside, Ltd., 1980.

A WORKSHOP FOR CAREGIVERS

2. TOPIC: Drugs and the Elderly

Educational Objective(s):

a) To explore the use of drugs (prescription and over-the-counter) that older people use with a view to challenging current patterns.

b) To encourage advocacy on the part of the older person or caregiver.

Resource People:

a) Pharmacist with a perspective on the problem of over-prescribed elderly people.

b) Older person who is active on the issue.

c) Home Care Nurse or Visiting Homemaker with some experience in the area.

Resource Material:

a) VIDEO: 16 minute, color,'**Can't you Give 'em Something**,' produced by PEI Department of Health and Social Services. See:TRAINING MANUAL ON AGING for details.

b) '**Improving with Age; How to enjoy your Senior Years**, Leslie Holbrook with Dr. George Merry, Deveau Publishers, Toronto, 1985, (Chapter 3).

c) '**An Easy Pill to Swallow**,' NFB, 29 minutes, 16mm. This documentary, in the form of an ongoing dialogue for and against drugs, introduces us to doctors and patients who approach this issue from different angles.

d) '**You and Your Medicine - A Guide for Senior Citizens**,' Ontario Pharmacist Association, 99 Avenue Road # 707, Toronto, ON M5G 2G5.

What to Do:

a) Have the pharmacist and the home care nurse present on the problem of poly-pharmacy or drug interactions that effect the health status of the older person.

b) Share experiences of seniors attending workshop.

c) Show the video, 'Can't you Give 'em Something.' A video that examines a successful drug reduction program in a provincial manor in Prince Edward Island.

FACTS:

a) On Doctors -

"In 'Our Chemical Society,' published in October 1981 by The Health Advocacy Unit, Department of Health, City of Toronto, it was reported that in one year (1978) the Canadian drug industry spent $154 million, or about $2,900 per doctor, on promoting its products to physicians. Doctors do not need and should not be subjected to such high-pressure merchandising. All they require is simple, straightforward scientific documentation as to what a drug can safely do." IMPROVING WITH AGE, Holbrook, Merry.

For more workshop ideas and formats, see THE TRAINING MANUAL ON AGING, Section III of this curriculum.

C. THE MEDIA

Radio - Seniors' Line: The CBC Charlottetown became interested in developing a weekly information program during the afternoon show (4-6 p.m.) The result of our collaboration iwth the CBC was Seniors' Line which began as a one-half hour guest interview and phone-in. The phone-in component was a little 'hair-raising' at times because the response wasn't what the CBC producer wanted it to be--the result was todrop the phone-in portion and concentrate on a shorter more concentrated format that aired senior issues. The following is a list of some of the topics:

CBCT RADIO 96.9 FM

a New Feature on Island Afternoon

SENIORS' LINE

Island Afternoon

Tuesdays 4:40-5:00

Each Tuesday on Island Afternoon, George MacNabb hosts a lively discussion on subjects of special interests to our aging population

Special guests stop by to talk about various topics, and answer questions from listeners. Senior's Line provides in-depth reports on subjects of major importance to Seniors.

Planning for retirement, health and recreation, coping with living alone, and money management are just a few of the subjects discussed on Seniors' Line.

We'd also like to hear from you. If there are special concerns which you would like considered on Seniors' Line, call us at 566-359[illegible]

- retirement planning;
- pensions: buying and cooking for one;
- healthy lifestyles for seniors;
- drugs and the elderly;
- the role of occupational therapy and the community based elderly;
- exercise;
- seniors pass on the culture: dentistry and oral care;
- learning at any age;
- advocacy;
- Alzheimer's Disease;
- snow removal in Ch'town-- a very hot topic with phone-in;
- home care in PEI; sexuality, foot care; etc.

The point of this shopping list is to convince the reader that any topic can be aired as relevant to the aging population. The importance of a regular weekly spot is not to be understated.

The mandate of CBC Radio is to present Canadians to themselves. Since over ten percent of the Canadian population is over sixty-five years of age, it is well within the mandate of the CBC to develop such a service as Seniors' Line elsewhere in Canada. Take this model and adapt it to your region.

Documentary Radio: Two radio documentaries which present the questions of drugs and natural caregivers in some detail were prepared by the CBC with assistance from the Gerontology Resource Person. They are drugs and the elderly, and the natural caregiver. (See Tools and Models - page 2.)

Television - Cable: (See Tools and Models - Section I, page 25)

Newspaper: The press are always interested in a good human interest story and the EPA project helped to direct the attention of the print media to positive aging stories.

The immediate assumption on the part of a news editor when presented with an 'Aging' story is that the story is going to be sad, negative, and end on a tragic note. However, this stereotype can soon be dispelled with the facts. The producer can be assured that dealing with pension reform or issues around housing will stimulate the larger portion of the listening audience as well as the specialized 'over 65' group that has a special interest in such questions.

The families (adult children) as well as neighbors and friends of seniors who require some change in housing would be a most appreciative audience.

Educational Videos - On the following three pages are descriptions of three educational videos produced by the Gerontology Resource Person for the public/service providers education.

EDUCATIONAL VIDEO

CAN'T YOU GIVE 'EM SOMETHING

18 minutes/color/video 3/4"/1984

Can't You Give 'em Something is a documentary shot on location at Summerset Manor, in Summerside, Prince Edward Island.

It explores the drug reduction program initiated there in 1978. The program has been successful in reducing the amount of drugs consumed by residents up to fifty percent. The elements that contributed to such results are presented. The physician, the resident, the nurse, and the administrator all play a role, and we hear from all these people in the course of the video.

The key person is, of course, Kathleen Corr, a former resident of the manor who now lives on her own. She tells her own story.

AVAILABLE FROM: Kevin Moynihan, Gerontology Resource Person
Educational Programs on Aging
Department of Health and Social Services
P. O. Box 2000, Charlottetown, PE C1A 7N8
TELEPHONE: 892-5471

COST: No charge - simply provide a blank video tape in your format (18-minute presentation).

EDUCATIONAL VIDEO

IN A LAND OF PLENTY

This 12-minute documentary video explores the major causes of mal-nutrition in the elderly who live alone. The effect of too many prescription and over-the-counter drugs; the tea and toast syndrome; myths about binding foods; and the relationship of milk products to preventive health care are explored.

The role of Meals-on-Wheels is presented as an alternative to institutionalized care. We travel to ALBERTON, P.E.I., where a successful program is in place and meet some of the people responsible.

This documentary, shot on location in Prince Edward Island, presents some of the preventive health care concerns of those who care for the community-based elderly. It is designed as an educational tool for these same service providers as well as the general public to help them to understand how older people living alone can be mal-nourished in a LAND OF PLENTY.

EDUCATIONAL VIDEO

THE PLACE TO BE

Shot on location in Prince Edward Island, this twenty-minute documentary explores some of the middle ground between the nursing home and the family home for older persons. The options are presented in three forms: the manor or nursing home; the community care facility (that provides no nursing care); and the private home or apartment with some community support.

Within these three large options, there are many variations and the people who appear in this film explain them. A bachelor who used to farm alone found that preparing meals was a bother so he lives in a group-style home in Charlottetown. A former post-mistress who lives alone in a huge family home explains why it's important to her to stay in her community--"never a nursing home," she says.

The individual heroism of independent people who live in the dwellings of their own choice comes through this video. And the importance of that choice is the message that comes through the interviews and profiles.

Written and directed by: **Kevin Moynihan, Gerontology Resource Person**
Health and Social Services (Dept.)

SECTION III

THE TRAINING MANUAL ON AGING

THE TRAINING MANUAL ON AGING

ATTITUDES ON AGING SESSIONS

KEVIN MOYNIHAN
GERONTOLOGY RESOURCE
EDUCATIONAL PROGRAMS ON AGING

JAN/86

INTRODUCTION

THIS MANUAL HAS BEEN ASSEMBLED TO ASSIST ANYONE INVOLVED IN PUBLIC EDUCATION ON THE QUESTION OF **ATTITUDES ABOUT AGING.** IT IS A PRODUCT OF A FEDERAL GRANT (HEALTH PROMOTION DIRECTORATE OF HEALTH AND WELFARE CANADA) TO THE PRINCE EDWARD ISLAND DEPT. OF HEALTH AND SOCIAL SERVICES CALLED THE **EDUCATIONAL PROGRAMS ON AGING.**

THE THEME: THIS BOOK IS DIVIDED INTO EIGHT SEPARATE CHAPTERS OR SESSIONS. EACH SESSION REPRESENTS AN EVENING OR A FEW HOURS OF DIRECTED LEARNING FOR AN ANIMATOR AND A GROUP. THE TOPICS RANGE FROM DRUG REDUCTION TO STEREOTYPES ON AGING; BUT THERE IS A THEME THAT RUNS THROUGH THE WHOLE MANUAL. THE THEME IS THAT WE CAN ALL DO WITH AN IMPROVEMENT IN OUR ATTITUDES ABOUT GROWING OLD, AND THAT 'IMPROVED' ATTITUDE WILL LEAD TO AN INCREASE IN OPPORTUNITIES FOR OLDER PEOPLE TO PLAY A MORE MEANINGFUL ROLE IN OUR SOCIETY, AS WELL AS TO A HIGHER QUALITY OF HEALTH CARE.

THE SERVICE PROVIDER/CAREGIVER CAN BE A NURSE IN A LONG-TERM CARE FACILITY, A FAMILY DOCTOR, OR A VOLUNTEER DRIVER FOR MEALS ON WHEELS. THE FAMILY IS THE PRIMARY CAREGIVER TO THE ELDERLY AND, AS SUCH, DESERVES OPPORTUNITIES TO DISCUSS AGING OR EVEN TO LEARN HOW TO HANDLE THE STRESS OF CARING FOR AGING PARENTS.

THIS MANUAL IS DESIGNED FOR ALL THOSE WHO WANT TO LEARN MORE ABOUT AGING.

KEVIN MOYNIHAN, GERONTOLOGY RESOURCE PERSON

1986

TABLE OF CONTENTS

SESSION ONE	Attitudes about Aging
SESSION TWO	Attitudes about Aging
SESSION THREE	The Fact and the Fiction
SESSION FOUR	Drugs and Nutrition
SESSION FIVE	Retirement
SESSION SIX	Caring For Aging Parents
SESSION SEVEN	A Stitch in Time
SESSION EIGHT	New Wrinkles on Old Attitudes

Suggested films and videos:

Generations (available from Aging and Extended Care Division)

Minnie Remembers (A-EC)

The Last of Life (Media Centre)

Wellness and Aging (EPA - Community Support Services)

Can't You Give 'em Something (EPA)

In a Land of Plenty (EPA)

As we Grow Older (A-EC)

Caring for Aging Parents (EPA)

A Stitch in Time (EPA)

Island Tel Commercial (EPA)

New Wrinkles on Old Attitudes (EPA)

SESSION ONE

ATTITUDES ABOUT AGING

(2 SHORT FILMS)

OBJECTIVE

THE PURPOSE OF THIS SESSION IS TO ASSIST THE LEARNER TO CLARIFY HIS/HER OWN ATTITUDES AND VALUES ABOUT AGING. THE EXERCISE IS ESSENTIAL TO THE PROCESS OF LEARNING NEW THINGS ABOUT AGING.

IT IS IMPORTANT THAT THE **ANIMATOR** RECOGNIZE THAT HELPING PEOPLE TO **CLARIFY** THEIR ATTITUDES MEANS THAT ONE DOESN'T IMPOSE ANOTHER POINT OF VIEW ON THEM. PEOPLE HOLD ONTO THEIR OWN ATTITUDES. THEY HAVE TAKEN YEARS TO DEVELOP THEM; THEY CHERISH THEM, AND BY AND LARGE, DON'T MIND GOING PUBLIC WITH THEM. ATTITUDES, THEREFORE, ARE VERY DIFFICULT TO CHANGE IN THE FIRST PLACE. SO BEING SATISFIED WITH A CLARIFICATION EXERCISE IS PROBABLY THE BETTER CHOICE.

METHOD: FILM 1 **(GENERATIONS)** SHOW THE FILM (AVAILABLE FROM DIVISION OF AGING AND EXTENDED CARE. CALL: 892-5471 EXT. 319).

MATERIAL: GENERATIONS - **13 MINUTES.** A FILM WITHOUT WORDS. THIS DELIGHTFUL PIECE PRESENTS A YOUNG BOY AND AN OLD MAN AS THEY MEET IN A CITY PARK AND EVENTUALLY BECOME FRIENDS. THE ASSUMPTIONS ABOUT THE OTHER GENERATION INTERFERE WITH THE PROCESS. FOR EXAMPLE, THE YOUNG BOY IS, AT FIRST, ANNOYED THAT THE OLD MAN WOULD LEAVE HIS PICNIC BLANKET TO LOOK TO USE THE SWINGS.

THE BOY CHALLENGES THE OLD MAN TO JUMP FROM THE SWING AT HIGH SPEED--THE OLD MAN DECLINES BUT CONTINUES TO TAKE THE CHALLENGE ON THE SLIDE AND THE MERRY-GO-ROUND. THE BOY IS INVITED TO JOIN THE OLD MAN AND HIS WIFE FOR A SANDWICH AFTER WHICH THE TWO NEW FRIENDS GO FOR A NATURE WALK THROUGH THE WOODS.

THE OLD MAN EXPLAINS THE VEGETATION AND THE INSECT LIFE TO THE ENRAPTURED BOY. THE FILM FINISHES WITH THE NEW INTERGENERATIONAL FRIENDS SHARING A MARVELOUS PENCIL SKETCH OF THE YOUTHFUL FACE OF THE BOY DRAWN BY THE OLD MAN.

THE OLD MAN HAS CAPTURED THE SPIRIT OF THE YOUNGER PERSON IN THIS SKETCH. **GENERATIONS** IS A VERY POSITIVE FILM.

WHAT TO DO AFTER THE FILM:

STEP 1: QUESTION? ASK PEOPLE TO HAVE A NOTE PAD AND PEN HANDY.

A) WHAT IMAGES COME BACK TO YOU AFTER THE FILM? START A LIST OF IMAGES OR MOMENTS IN THE FILM THAT YOU RECALL.

B) WHAT SOUNDS COME BACK TO YOU? START ANOTHER LIST.

C) SHARE YOUR LIST WITH YOUR NEIGHBOR FOR A FEW MINUTES.

TO THE ANIMATOR: THIS EXERCISE IS DESIGNED TO "PRIME THE PUMP" A BIT. WHEN IT IS COMPLETE, YOU WILL FIND, NOT ONLY THAT YOUR GROUP WANTS TO TALK, BUT THAT IT ALSO HAS LOTS OF MATERIAL TO TALK ABOUT.

STEP 2:

D) WHAT SORT OF IMAGE OF AGING IS PRESENTED IN THE FILM?

E) WHAT DO YOU THINK GOES ON IN THE MIND OF THE BOY WHEN THE OLD MAN FIRST APPROACHES THE SWING? WHAT WENT ON IN YOUR OWN MIND?

FILM 2 (MINNIE REMEMBERS) 5 MINUTES - SHOW THE FILM (ALSO AVAILABLE FROM THE SAME SOURCE AS FILM 1).

MINNIE REMEMBERS IS A BITTER-SWEET FLASHBACK THAT TAKES PLACE IN THE MIND OF A WOMAN CONFINED BY A PHYSICAL DISABILITY TO A NURSING HOME IN THE COUNTRY. SHE REMEMBERS HOW SHE TOUCHED HER CHILDREN AND HOW THEY TOUCHED HER FOR COMFORT AND SOLACE. SHE REMEMBERS "HANK" HER LATE HUSBAND AND HOW THE TOUCH OF LOVERS IS SO SPECIAL.

TODAY HER CHILDREN AND GRANDCHILDREN VISIT HER BUT SHE NOTES, WITH SOME SADNESS, WITHOUT TOUCHING HER, THE WAY SHE REMEMBERS BEING TOUCHED THROUGHOUT HER LIFE.

WHAT TO DO AFTER THE FILM:

A) QUESTIONS 1 - 2 - AND 3 CAN BE USED AGAIN IN ORDER TO "PRIME THE PUMP" FOR MORE FRUITFUL DISCUSSION.

B) DOES MINNIE NEED TO BE TOUCHED? DO <u>YOU</u> NEED TO BE TOUCHED?

C) HOW DO YOU FEEL ABOUT MINNIE'S STATEMENT: "IT'S BEEN TWENTY YEARS SINCE ANYONE HAS TOUCHED ME"?

D) ARE THE ELDERLY ANY DIFFERENT FROM YOU AND ME IN THIS RESPECT?

SESSION TWO

ATTITUDES ABOUT AGING

AGING QUIZ AND ROLE PLAYING

OBJECTIVE

THE PURPOSE OF THIS SESSION IS TO ASSIST IN CLARIFYING THE VALUES OF THE PARTICIPANTS WHILE CHALLENGING THEIR ASSUMPTIONS ABOUT AGING PEOPLE. THE SECOND PART OF THE SESSION IS DESIGNED TO ALLOW A LITTLE DRAMA TO ENTER THE DISCUSSION. THIS ROLE-PLAYING EXERCISE IS BASED ON THE ASSUMPTION THAT PEOPLE HAVE SOLUTIONS TO MAJOR LIFE QUESTIONS WITHIN THEMSELVES. ALL THEY NEED TO DO IS UNLOCK THEM. ROLE-PLAYING IS ONE VERY EFFECTIVE WAY OF DOING JUST THIS.

THE NATIVE PHILOSOPHER IS REPUTED TO HAVE SAID THAT YOU CANNOT UNDERSTAND ANOTHER PERSON UNLESS FIRST YOU "WALK A MILE IN HIS MOCCASINS." THIS EXERCISE APPROACHES THAT EXPERIENCE.

THE FIRST HALF OF THIS SESSION WILL BE SPENT TAKING A TRUE/FALSE QUIZ DESIGNED BY ERDMAN PALMORE ENTITLED **"THE FACTS OF AGING: A SHORT QUIZ."** APPENDIX A.

THE KEY ACCORDING TO PALMORE TO THE FACTS ON AGING QUIZ (1977) IS SIMPLE. ALL THE ODD NUMBERED ITEMS ARE FALSE AND ALL THE EVEN NUMBERED ARE TRUE.

IF THE ANIMATOR DOESN'T HAVE ENOUGH COPIES TO GO AROUND, S/HE CAN INSTRUCT THE PARTICIPANTS TO WRITE THE NUMBERS 1 THROUGH 25 ON A SHEET OF PAPER AND PROCEED TO READ THE 25 QUESTIONS TO THE GROUP.

THE PARTICIPANTS SIMPLY INDICATE THEIR CHOICE (TRUE OR FALSE) AFTER EACH NUMBER. THE ANSWERS AND SOME EXPLANTIONS ARE AVAILABLE IN APPENDIX A.

IT MIGHT BE INTERESTING FOR YOU TO KNOW THAT SOME OF THE ERRORS MOST COMMON TO RESPONDENTS TO THIS QUIZ ARE THE FOLLOWING:

THE PROPORTION OF THE AGED POPULATION IN LONG-TERM CARE FACILITIES.

THE INFLEXIBILITY OF THE AGED.

THE BOREDOM OF OLD AGE.

THE PROPORTION OF THE POPULATION OVER 65.

THE FINANCIAL STATUS OF THE AGED.

PATTERNS OF IRRITABILILTY AMONG THE AGED.

OTHER COMMON MISCONCEPTIONS INVOLVE THE DECLINE IN SENSES AND LUNG CAPACITY AND THE RELIGIOSITY OF THE AGED. YOUR GROUP MAY HAVE THE SAME ASSUMPTIONS ABOUT THE ELDERLY AS MOST

THERE IS A CANADIAN VERSION WITH UPDATED CANADIAN STATISTICS--APPENDIX B. THIS MAY PROVE USEFUL.

THERE IS A **FACTS ON AGING QUIZ: PART II** DEVELOPED AS A SEQUEL BY ERDMAN PALMORE IN 1981--APPENDIX C.

ROLE PLAYING

THE SECOND PART OF THIS SESSION WILL INCORPORATE A CASE STUDY APPROACH OR A ROLE-PLAYING SITUATION. THE EXERCISE IS MEANT TO BE NON-THREATENING, SO NAMES OF TOWNS AND PERSONALITIES SHOULD BE LEFT OUT OF THE SCRIPT.

BASICALLY, THE ANIMATOR CAN DESIGN A CASE STUDY WITH FOUR OR FIVE PLAYERS THAT WILL ASSIST THE GROUP TO UNDERSTAND SOME OF THE TENSIONS AROUND AGING.

AN EXAMPLE: SEVENTY-ONE YEAR-OLD, **MRS. BROWN**, IS A RECENT WIDOW AND HAS BEGUN TO NEGLECT HER HOME AND GARDEN. SHE HAS ACCUSED HER NEIGHBOR, **MRS. GREEN**, OF SENDING POISONOUS GASES IN THROUGH THE ADJOINING KITCHEN DOOR IN ORDER TO KILL HER NEIGHBOR OF MANY YEARS.

MR. SMITH IS A NEPHEW OF **MRS. BROWN'S** AND HE IS CONVINCED ABOUT PLACING **MRS. BROWN** IN A LONG-TERM CARE FACILITY.

DR. ROBERTS HAS BEEN CALLED IN TO RENDER A MEDICAL OBSERVATION AND IS UNDER SOME PRESSURE BY THE NEPHEW AND NEIGHBOR TO MOVE **MRS. BROWN** TO A NURSING HOME.

YOU CAN INVENT A SOCIAL WORKER TO SPEAK ON BEHALF OF **MRS. BROWN**, A CLERGYMAN TO ADD A DIMENSION, ANOTHER NEIGHBOR OR REAL ESTATE AGENT TO HEIGHTEN THE TENSION.

ASK FOR VOLUNTEERS TO PLAY THEIR ROLES AT A SIMULATED GROUP MEETING. THE EXERCISE SHOULD LAST ONLY TEN OR FIFTEEN MINUTES, SO WHEN YOU NOTICE THIS DRAMA HAS "FIZZLED OUT," STOP THE ROLE-PLAYING EXERCISE AND MOVE THE GROUP INTO DISCUSSION OF WHAT HAS HAPPENED.

YOU MIGHT ASK THE PLAYERS TO EXPRESS HOW THEY FELT IN THEIR ROLES AND WHETHER THEY EVER COULD SEE THEMSELVES IN SUCH A SITUATION. THIS OFTEN LEADS TO A LEVEL OF DISCUSSION THAT IS VERY FRUITFUL.

THE GROUP THAT OBSERVED THE ROLE-PLAYING MIGHT BE INVITED TO COMMENT ON HOW THEY FELT ABOUT MRS. BROWN'S SITUATION AND WHAT SORT OF SOLUTION THEY COULD SEE.

GIVING SOME WILLING VOLUNTEERS AN OPPORTUNITY TO DISCUSS THE DRAMA, THIS EXERCISE CAN GO A LONG WAY IN CLARIFYING VALUES AND ATTITUDES ABOUT AGING. IT WILL ALSO HELP TO BREAK DOWN BARRIERS BETWEEN PARTICIPANTS AND MAKE THE NEXT SESSIONS EVEN MORE ENJOYABLE.

APPENDIX "A"

A short, factual, and documented quiz is developed and tested which covers the basic facts and frequent misconceptions about aging. Its uses include stimulating discussion, measuring levels of information and anti-aged bias, identifying the most frequent misconceptions, measuring the effects of courses, and measuring changes in public information or bias.

Facts on Aging
A Short Quiz[1]

Erdman Palmore, PhD[2]

Several tests or scales on aging have been developed and a few have been published (Golde & Kogan, 1959; Kogan, 1961; Tuckman & Lorge, 1952). However, these tests all share one or more of the following disadvantages:

(1) They tend to have 40 or 50 items and require several pages of print.

(2) They confuse factual statements (which may or may not be true) with attitudinal statements which are arbitrarily scored as being "favorable" or "unfavorable." For example, Kogan's statement "Most old people would prefer to continue working just as long as they can, rather than be dependent on anybody" is probably false, depending on what is meant by "most," "working," .and "dependent." Yet, a "disagree" response is scored as showing an unfavorable attitude toward the aged. Unfortunately, some "negative stereotypes" about the aged are generally true and some of the "positive" statements are generally false.

(3) The factual statements are undocumented and we have nothing but the author's assertion that they are true or false.

The following quiz is designed to avoid these disadvantages. It is short (25 items requiring only one page and less than 5 minutes to complete) and confined to factual statements which can be documented by empirical research. It is designed to cover the basic physical, mental, and social facts and the most common misconceptions about aging. Before proceeding further, you are encouraged to try out the quiz to find out which facts you may be unaware of. Circle "T" for True, or "F" for False.

T F 1. The majority of old people (past age 65) are senile (i.e. defective memory, disoriented, or demented).
T F 2. All five senses tend to decline in old age.
T F 3. Most old people have no interest in, or capacity for, sexual relations.
T F 4. Lung capacity tends to decline in old age
T F 5. The majority of old people feel miserable most of the time.
T F 6. Physical strength tends to decline in old age.
T F 7. At least one-tenth of the aged are living in long-stay institutions (i.e. nursing homes, mental hospitals, homes for the aged, etc.).
T F 8. Aged drivers have fewer accidents per person than drivers under age 65.
T F 9. Most older workers cannot work as effectively as younger workers.
T F 10. About 80% of the aged are healthy enough to carry out their normal activities.
T F 11. Most old people are set in their ways and unable to change.
T F 12. Old people usually take longer to learn something new.
T F 13. It is almost impossible for most old people to learn new things.
T F 14. The reaction time of most old people tends to be slower than reaction time of younger people.
T F 15. In general, most old people are pretty much alike.
T F 16. The majority of old people are seldom bored.
T F 17. The majority of old people are socially isolated and lonely.
T F 18. Older workers have fewer accidents than younger workers.

[1]Research for this article was supported in part by Grant AG-00364, NIA, USPHS. The author wishes to thank all the students and faculty who participated in the development and testing of this quiz. Jane Crosby did the tabulations for the tables.

[2]Professor of Medical Sociology and Senior Fellow at the Center for the Study of Aging and Human Development, Box 3003, Duke Univ. Medical Center, Durham 27710.

T F 19. Over 15% of the U.S. population are now age 65 or over.

T F 20. Most medical practioners tend to give low priority to the aged.

T F 21. The majority of older people have incomes below the poverty level (as defined by the Federal Government).

T F 22. The majority of old people are working or would like to have some kind of work to do (including housework and volunteer work).

T F 23. Older people tend to become more religious as they age.

T F 24. The majority of old people are seldom irritated or angry.

T F 25. The health and socioeconomic status of older people (compared to younger people) in the year 2000 will probably be about the same as now.

The key to the correct answer is simple: all the odd numbered items are false and all the even numbered are true. So far, no one taking the quiz has guessed this pattern of correct answers.

Documentation

(1) The majority of old people are not senile (i.e., defective memory, disoriented, or demented). Only about 2 or 3% of persons age 65 or over are institutionalized as a result of psychiatric illness (Busse & Pfeiffer, 1977). A series of eight community surveys found the prevalence of psychosis (of all types) to range from 4 to 8% (Riley & Foner, 1968). Thus, all the evidence indicates that there are less than 10% of the aged who are disoriented or demented. It is more difficult to get accurate estimates of the proportion with defective memories, partly because of the different types of memory defects and different methods of measuring it. However, most studies agree that there is little or no decline with age in short-term memory storage capacity (using the digit span test). Four studies did find large age differences in free recall of words, but two of them found no age differences in recognition of words in a list (Woodruff & Birren, 1975). As for long-term memory, various community surveys have found less than 20% of the aged who cannot remember such things as the past President of the United States, their correct age, birth date, telephone number, mother's maiden name, address, or the alphabet (Botwinick, 1976; Pfeiffer, 1975). Thus, it is clear that the majority of aged do not have such serious memory defects.

(2) All five senses do tend to decline in old age. Most studies agree that various aspects of vision, hearing, and touch tend to decline in old age. Some studies of taste and smell have not found a significant decline, but the best evidence indicates increases in taste and smell threshholds with age (Riley & Foner, 1968). Studies of structural atrophy in the tongue and nose with old age support the experimental evidence of decline in taste and smell (Birren, 1959).

(3) The majority of persons past age 65 continue to have both interest in, and capacity for, sexual relations. Masters and Johnson (1966) found that the capacity for satisfying sexual relations continues into the decades of the 70s and 80s for healthy couples. The Duke Longitudinal Studies found that sex continues to play an important role in the lives of most men and the majority of women through the seventh decade of life (Palmore, 1974).

(4) Lung capacity does tend to decline in old age. Both vital lung capacity (the volume of air that can be forcibly expelled in one breath) and maximum breathing capacity (the volume of air that can be moved in and out of the lungs in 15 seconds) declines on the average from age 30 onward (Shock, 1962).

(5) The majority of old people do not feel miserable most of the time. Studies of happiness, morale, and life satisfaction either find no significant difference by age groups or find about one-fifth to one-third of the aged score "low" on various happiness or morale scales (Riley & Foner, 1968). A recent national survey found that less than a fourth of persons 65 or over reported that "This is the dreariest time of my life"; while a majority said "I am just as happy as when I was younger" (Harris, 1975).

(6) Physical strength does tend to decline in old age. Studies of various kinds of muscular strength show declines in old age compared to young adulthood of 15 to 46% (Birren, 1959).

(7) Only 4.8% of persons 65 or over were residents of any long-stay institutions in 1970 (U.S. Census, 1970). Even among those age 75 or over only 9.2% were residents in institutions.

(8) Drivers over age 65 do have fewer accidents per person than drivers under age 65. Older drivers have about the same accident rate per person as middle-aged drivers, but a much lower rate than drivers under age 30

(National Safety Council, 1976). Older drivers tend to drive less miles per year and apparently tend to compensate for any declines in perception and reaction speed by driving more carefully.

(9) The majority of older workers can work as effectively as younger workers. Despite declines in perception and reaction speed under laboratory conditions among the general aged population, studies of older workers (the 12% who are able to continue employment) under actual working conditions generally show that they perform as well as young workers, if not better than younger workers, on most measures. When speed of reaction is important, older workers sometimes produce at lower rates, but they are at least as accurate and steady in their work as younger workers. Consistency of output tends to increase by age, as older workers perform at steadier rates from week to week than younger workers do. In addition, older workers have less job turnover, less accidents, and less absenteeism than younger workers (Riley & Foner, 1968).

(10) About 80% of the aged are healthy enough to engage in their normal activities. About 5% of those over age 65 are institutionalized and another 15% among the noninstitutionalized say they are unable to engage in their major activity (such as work or housework) because of chronic conditions. This leaves 80% who are able to engage in their major activity (National Center for Health Statistics, 1974).

(11) The majority of old people are not "set in their ways and unable to change." There is some evidence that older people tend to become more stable in their attitudes, but it is clear that most older people do change and adapt to the many major events that occur in old age such as retirement, children leaving home, widowhood, moving to new homes, and serious illness. Their political and social attitudes also tend to shift with those of the rest of society, although at a somewhat slower rate than for younger people (Cutler & Kaufman, 1975; Glenn & Hefner, 1972).

(12) Old people usually take longer to learn something new. Experiments have consistently shown that older people take longer than younger people to learn new material (Botwinick, 1967). Studies of on-the-job trainees also show that older workers tend to take somewhat longer to learn new jobs (Riley & Foner, 1968).

(13) But, it is not impossible for most old people to learn new things. The same studies (cited in #12) also show that most older persons can eventually learn new things about as well as younger persons, if given enough time and repetitions of the material to be learned.

(14) The reaction time of most old people tends to be slower than that of younger people. This is one of the best documented facts about the aged on record. It appears to be true regardless of the kind of reaction that is measured (Botwinick, 1967).

(15) Most old people are not pretty much alike. There appears to be at least as much difference between older people as there is at any age level; there are the rich and poor, happy and sad, healthy and sick, high and low intelligence, etc. In fact, some evidence indicates that as people age they tend to become less alike and more heterogeneous on many dimensions (Maddox & Douglas, 1974).

(16) The majority of old people are seldom bored. Only 17% of persons 65 or over say "not enough to do to keep busy" is a "somewhat serious" or "very serious" problem (Harris, 1975). Another survey found that two-thirds of the aged said they were never or hardly ever bored (Dean, 1962). The Duke Adaptation Study found that 87% of those 65 or over said they were never bored in the past week.

(17) The majority of old people are not socially isolated and lonely. About two-thirds of the aged say they are never or hardly ever lonely (Dean, 1962), or say that loneliness is not a serious problem (Harris, 1975). Most older persons have close relatives within easy visiting distance and contacts between them are relatively frequent (Binstock & Shanas, 1976). About half say they "spend a lot of time" socializing with friends (Harris, 1975). About three-fourths of the aged are members of a church or synagogue (Erskine, 1964), and about half attend services at least three times per month (Catholic Digest, 1966). Over half belong to other voluntary organizations (Hausknecht, 1962). Thus, between visits with relatives and friends and participation in church and other voluntary organizations, the majority of old people are far from socially isolated.

(18) Older workers have fewer accidents than younger workers. Most studies agree this is true. For example, a study of 18,000 workers in manufacturing plants found that workers beyond age 65 have about one-half

the rate of nondisabling injuries as those under 65, and older workers have substantially lower rates of disabling injuries (Kossoris, 1948).

(19) Only 10.3% of the population were age 65 or over in 1975 and this will probably not increase to more than 12% by the year 2000, even if completed fertility drops to zero population growth levels (Current Population Survey, 1975).

(20) Most medical practioners tend to give low priority to the aged. A series of 12 empirical studies all found that most medical students and doctors, nursing students and nurses, occupational therapy students, psychiatry clinic personnel, and social workers tend to believe the negative stereotypes about the aged and prefer to work with children or younger adults rather than with the aged. Few specialize, or are interested in specializing, in geriatrics (Brown, 1967; Campbell, 1971; Coe, 1967; Cyrus-Lutz & Gaitz, 1972; DeLora & Moses, 1969; Gale & Livesley, 1974; Garfinkel, 1975; Gunter, 1971; Miller, Lowenstein, & Winston, 1976; Mills, 1972; Spence & Feigenbaum, 1968).

(21) The majority of persons 65 or over have incomes well above the poverty level. In 1975 there were only 15.3% of the aged below the official poverty level (about $2,400 for an aged individual or $3,000 for an aged couple). Even if the "near poor" are included, the total in or near poverty is only 25.4% (Brotman, 1976).

(22) Over three-fourths of old people are working or would like to have some kind of work to do (including housework and volunteer work). There are about 12% of persons 65 or over who are employed, 21% who are retired but say they would like to be employed, 17% who work as housewives, 19% who are not employed but do volunteer work, and another 9% who are not employed and not doing volunteer work but would like to do volunteer work (Harris, 1975). These percentages total to 78%.

(23) Older people do not tend to become more religious as they age. While it is true that the present generation of older persons tend to be more religious than the younger generations, this appears to be a generational difference (rather than an aging effect) due to the older persons' more religious upbringing. In other words, the present older generation has been more religious all their lives rather than becoming more religious as they aged. Longitudinal studies have found no increase in the average religious interest, religious satisfaction, nor religious activities among older people as they age (Blazer & Palmore, 1976).

(24) The majority of old people are seldom irritated or angry. The Kansas City Study found that over one-half the aged said they are never or hardly ever irritated and this proportion increases to two-thirds at age 80 or over. About three-fourths said they are never or hardly ever angry (Dean, 1962). The Duke Adaptation Study found that 90% of persons over age 65 said they were never angry during the past week.

(25) The health and socioeconomic status of older people (compared to younger people) in the year 2000 will probably be much higher than now. Measures of health, income, occupation, and education among older people are all rising in comparison to those of younger people. By the year 2000, the gaps between older and younger persons in these dimensions will probably be substantially less (Palmore, 1976).

Uses

There are several possible uses for this quiz which we will discuss and illustrate. The simplest use is as a stimulus for group discussion and clarification of misconceptions. Whenever I have presented the quiz to a group, it always stimulates many questions and considerable discussion of the basis for these facts and of their implications.

Table 1. Facts on Aging Scores for Undergraduates, Graduates, and Faculty

Group	N	Mean % Right	Standard Deviation
Undergraduate students	87	65	11.2
Graduate students	44	80	7.5
Faculty	11	90	7.7

A second use is to measure and compare different groups' overall levels of information about aging. For example, Table 1 shows that a sample of Duke undergraduate students (in Introductory Sociology classes) got only two-thirds of the facts correct, compared to 80% correct among graduate students in human development (at Duke University and Pennsylvania State University), and 90% correct among faculty in human development (at Duke and Pennsylvania State). These differences also support the validity of the quiz. The only item on which more errors were

made by graduate students and faculty than by undergraduates is Item #22: "The majority of older people are working or would like to have some kind of work to do (including housework and volunteer work)." Apparently, most undergraduates believed correctly that the majority of aged do some kind of work or want to work, but there were 4 faculty and 5 graduate students who were unaware of how the various categories of working, housework, volunteer work, and wanting work or volunteer work, add up to well over half the elderly.

It would be interesting and useful to find out which age, sex, race, religious, regional, socioeconomic, and other groups have more or less correct information about aging.

A third use is to identify the most frequent misconceptions about aging. Table 2 shows that the most frequent misconceptions among the sampled undergraduates were that a large proportion of the aged are living in institutions (74% wrong); that a majority of the aged are frequently bored (74% wrong); that over 15% of the population are age 65 or over (86% wrong); and that a majority of older people have incomes below the poverty level (74% wrong). Almost half of even the faculty thought that a majority of the aged were in poverty. Notice that three of these frequent misconceptions are negative stereotypes and that the other one exaggerates the problem of the aged by exaggerating the numbers of aged.

Table 2. Percentage of Errors on Each Statement by Undergraduates, Graduates, and Faculty.

Statement #	% Errors by: Undergraduates	Graduates	Faculty
1	7	0	0
2	40	14	27
3	16	2	0
4	21	16	9
5	12	0	0
6	2	7	0
7	74	27	0
8	40	27	18
9	37	2	0
10	9	0	0
11	47	9	0
12	47	30	9
13	5	0	0
14	7	7	0
15	9	2	0
16	74	73	55
17	42	16	0
18	42	18	0
19	86	55	36
20	56	9	9
21	74	50	45
22	2	11	36
23	63	44	18
24	58	73	0
25	21	18	18

A fourth use is as an indirect measure of bias toward the aged. Errors on some of the items probably indicate a negative bias toward the aged: for example, if someone says it is true that a majority of old people are senile (#1), it probably indicates a negative image of the aged. On the other hand, errors on other items probably indicate a positive bias toward the aged: for example, if someone denies that the five senses tend to decline in old age (#2) it probably indicates an unrealistically favorable image of old age. We have classified sixteen items as indicating a negative bias if they are marked incorrectly: items numberd 1, 3, 5, 7, 8, 9, 10, 11, 13, 16, 17, 18, 21, 22, 24, and 25. On the other hand, we have classified five items as indicating a positive bias if they are marked incorrectly: items numbered 2, 4, 6, 12, and 14. Using these items, one can then compute a net anti-aged or pro-aged score by subtracting the percentage of errors on the negative bias items from the percentage of errors on the positive bias items. If the resulting score is negative, it indicates a net anti-aged bias; if it is positive, it indicates a net pro-aged bias. For example, 12 of the undergraduates had net anti-aged scores of 33 or more, and 5 had net pro-aged scores of 33 or more. Table 3 shows that the undergraduates and graduates tended to have more anti-aged errors than pro-aged errors, but that there was little difference in anti-aged and pro-aged errors among the faculty. About 2/3 of the undergraduates had net anti-aged bias. It would be useful to know which groups in the population tend to have high or low anti-aged bias.

Table 3. Pro- and Anti-Aged Errors for Undergraduates, Graduates, and Faculty.

Group	N	Mean % Pro-Errors	Mean % Anti-Errors	% Pro minus % Anti
Undergraduate students	87	26	33	-7
Graduate students	44	15	20	-6
Faculty	11	9	11	-2

A final use of the quiz would be to measure the effects of lectures, courses, or other training experiences by comparing before and after scores; both total scores and the net anti-

aged scores. A longer test with multiple choice format might be a more sensitive measure, but this quiz has the advantage of requiring only a few minutes without taking much time away from the lecture or course itself. Similarly, periodic administrations of the quiz to representative samples of the public could be used to gauge changes in information levels and biases of the public as a whole.

Summary

Previous tests on aging tend to be long, undocumented, and confuse factual statements with attitudes. The present quiz is short (25 items on one page), documented, and consists of factual statements only. It is designed to cover the basic physical, mental, and social facts and the most frequent misconceptions about aging. It may be used to stimulate discussion; compare levels of information in different groups (undergraduates averaged 65% correct, graduates averaged 80%, and faculty averaged 90%); to identify frequent misconceptions; to measure anti-aged or pro-aged bias (there is usually more anti-aged than pro-aged bias); and to measure the effects of courses or training materials or to measure changes in information or biases over time.

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APPENDIX "B"

THE FACTS ON AGING QUIZ: A CANADIAN VALIDATION AND CROSS-CULTURAL COMPARISON

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ABSTRACT

The "Facts on Aging Quiz" developed by Erdman Palmore has been extensively utilized as a brief, reliable, and easily administered test of factual knowledge on aging. This paper describes the applicability of the quiz in the Canadian context, and provides documentation for quiz items. Potential problems of misinterpretation of items relating to the rate of institutionalization and income levels, are noted. The paper also compares levels of knowledge and areas of misinformation among a sample (n=585) of undergraduates, university faculty, and health care professionals. The usefulness of the quiz in identifying differences in knowledge levels, is confirmed.

There has been a recent proliferation of courses and educational programmes in gerontology within Canadian universities and community colleges, and in-service programmes for social and health care professionals. Thus the need for a standardized mechanism to evaluate the level of factual knowledge of aging and age-related processes has become increasingly apparent. Ideally, such an instrument would serve two purposes. First, it would permit the evaluation of some objective 'level' of knowledge, and second, it would also facilitate the delineation of common misperceptions and *areas* of knowledge gap among programme participants. Thus, the measure would be useful for pre- and post- test assessments of the effectiveness of an educational programme. In addition, it could serve as a tool for the identification of necessary areas of focus and clarification within a given educational package.

One standardized instrument for such purposes is the well-known "Facts on Aging Quiz," developed by Erdman Palmore (1977) in response to a perceived need for a brief, reliable and easily administered test of factual knowledge on aging. The quiz has been widely used and some results have been published (Klemmack, 1978; Holtzman & Beck, 1979; Luszcz, 1982; Miller & Dodder, 1980; Palmore, 1978, 1980, 1981; Romeis & Sussman, 1982). None of these reports, however, have examined the findings of *Canadian* research. Given that many age-related issues may be specific to a particular culture, and affected by sociopolitical structure, it is important to gather some normative information on Canadian students and professionals. This paper is the report of findings based on the administration of the "Facts on Aging Quiz" to students, and selected faculty at the University of Guelph, and to a group of public health nurses in three southern Ontario Regional Health Units.

The quiz is designed to cover the basic physical, mental, and social facts as well as

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the most common misperceptions about aging. Palmore (1977) has described four possible uses for the quiz: 1) to stimulate group discussion and clarify misconceptions; 2) to measure and compare different groups' overall levels of information about aging; 3) to identify the most frequent misconceptions about aging; 4) to measure bias toward the aged. Administrations of the quiz have generally confirmed its usefulness for the first and third points; that is, as a group stimulus and in identifying misconceptions about aging. There is, however, some debate about whether it actually measures knowledge and age bias. For example, Klemmack (1978) found a low item-to-total correlation, which he took to indicate that the test was a poor measure of overall knowledge. On the other hand, Holtzman and Beck (1979) found that the quiz *did* effectively measure knowledge, but question, as do Romeis and Sussman (1982), its ability to adequately measure age bias. Elsewhere we have examined the controversial age bias issue (see Norris, Tindale & Martin Matthews, 1984); however, for purposes of this paper, we will accept the ability of the quiz to achieve our pedagogical objectives of 1) measuring overall levels of information, and 2) identifying misconceptions about aging.

The purpose of this paper, then, is to provide Canadian documentation for the demographic items in the Quiz,[1] and to compare knowledge and misconceptions among freshman and senior undergraduates, university faculty, and practising health care professionals. While Palmore (1981) has recently developed an alternative form of the quiz, and other authors (Miller & Dodder, 1980) have suggested revisions to improve the sensitivity of the instrument, the findings reported in this paper are based on the original instrument. This is done in order to maximize the comparability of our findings with those of previous research.

As Luszcz (1982) has noted in providing an Australian validation for the quiz, some of the 'facts' measured by quiz items ar demographic nature, and might, there be expected to vary between the U States (where it was developed), and countries. Luszcz found Australian mentation to support each of the 'd graphic' items (No. 1, 7, 8, 10, 19 and and it is similarly appropriate to con their validity in the Canadian con Numbers in parentheses in the ensuing cussion refer to statements in the quiz

Canadian Documentation:

(1) *The majority of old people (past 65) are senile (i.e., defective mem disoriented, or demented).* (False

While national Canadian figures on incidence of senility are not available, and Bergmann (1980), in an analysis of valence figures in a number of count report that dementia is relatively unc mon: that is, that severe or moderate f average 6.3 percent of the over 60 pop tion across 18 studies (1980: 42). T article cites the work of Harding and leagues (Harding, Leighton, Leigh Macklin, & MacMillan, 1963) in the culation of a 5.9 percent incidence rat the Canadian population aged 60 and c based on a sample of 270 in a commu survey.

(7) *At least one-tenth of the aged are li in long-stay institutions (i.e., nur homes, mental hospitals, homes fo aged, etc.).* (False)

Palmore (1977) cites a 4.8 percent i tutionalization rate for the U.S. popula aged 65 and over, and Luszcz (1982) percent rate for Australia. The compar Canadian figure for percent of aged per in various types of institutions at any g time is 8.4 percent (Schwenger and Gr 1980). However, some confusion ma generated in reference to this item, by no provincial variations in rates of inst tionalization (Schwenger and Gross, 19 248-256). In 1976, Alberta had a rat

9.4 percent of aged persons in various types of institutions. Other provinces had the following distributions: Manitoba 9.1 percent, Ontario 8.9 percent, Prince Edward Island, 7.9 percent, and Newfoundland 5.6 percent of aged persons in various types of institutions. Hence, unless people are aware that the various provincial averages may vary markedly from the national average, it is possible that relatively informed individuals will miss on this question in the Palmore Quiz.

An additional source of confusion may lie in Canadian data on the percentage of the aged population living in 'collective dwellings', defined as "a dwelling of a commercial, institutional or communal nature." *The Fact Book on Aging in Canada* (1983:68) states that 9 percent of the population aged 65 and over lived in such dwellings in 1981. However, because this calculation includes those aged living in "hotels, motels, tourist homes, lodging and roominghouses, school residences, and YM/YWCA's, etc.", it is not at all comparable to Palmore's and Schwenger and Gross' figures on rates of institutionalization. This somewhat misleading figure does, however, come quite close to the "one-tenth of the aged" noted in item 7, so here again it is possible that comparatively knowledgeable persons will score this item incorrectly. This quiz item should, perhaps, be altered to read "at least 15 percent" to be more 'fair' in the Canadian context.

(8) *Aged drivers have fewer accidents per person than drivers under age 65.* (True)

Although national statistics are not available, the Ontario Ministry of Transportation and Communications (1980) reports that while 3.3 percent of drivers aged 65 to 74, and 3.3 percent of drivers aged 75 and over, were involved in motor vehicle accidents in 1980, fully 22.3 percent of under age 16 drivers, 9.2 percent of drivers aged 21-24, and 4.7 percent of drivers 45-54 were involved. No other age group in Ontario had a per driver accident rate as low as that of the 65+ group. We have no reason to believe that this rate would vary markedly across Canada.

(10) *About 80 percent of the aged are healthy enough to carry out their normal activities.* (True)

It is rather difficult to establish precisely comparable Canadian documentation for this statement. For example, the *Fact Book on Aging in Canada* (1983:56) states: "The Canada Health Survey reported that . . . the major activity of about one-third (36 percent for males and 34 percent for females) of those aged 65 and over had been partially or totally limited at some time in the previous 12 months as opposed to 9 percent of the population aged 15-64."

However, because of the limited time frame ("over 12 months," rather than at any one point in time) and also because of the statistic's failure to distinguish between the partially and totally impaired, this figure does not specifically prove the veracity of the quiz statement in the Canadian context. Nevertheless, it does *suggest* that since fully two-thirds were not even partially impaired in their functioning, there is no reason to believe that it is less true in Canada than in the United States.

(19) *Over 15 percent of the Canadian population are now age 65 or over.* (False)

The 1981 Census of Canada, as reported in the *Fact Book on Aging in Canada* (Health and Welfare Canada, 1983) indicates that 9.7 percent of the Canadian population was age 65 and over in 1981.

(21) *The majority of older people have incomes below the poverty level (as defined by the Federal Government).* (False)

In Canada, the majority of those age 65 and over fall above the low income cut-off (with the cut-off being for those families spending 62 percent or more of their income on food, clothing and shelter). It is worth noting that in Canada this "low income cut-off" is

tabulated on the basis of the Consumer Price Index, and does not represent a government-set official poverty level, as is done in the United States. In the Canadian context, then, the more appropriate wording for this item is "The majority of older people have incomes below the low-income cut-offs as established by Statistics Canada."

The incidence of low income families in which the "head of the household" was 65 years of age or older was 14.9 percent (Statistics Canada, 1981), and 50.3 percent for unattached individuals age 65 and over. On average, then, the majority fall above the low-income cut-off[2].

As this documentation of pertinent Canadian data has indicated, the aged in both Canada and the United States share many characteristics, to the extent that the correct answers to the quiz are essentially the same in both countries. As will be shown later in this paper, there are also many similarities in the knowledge and misconceptions shared by students and professionals in both countries.

Methods:

Participants in the study were three classes of undergraduate students enrolled in Family Studies courses at the University of Guelph; faculty in the Department of Family Studies; and three groups of public health nurses. The first-year students (n=258) were enrolled in a Human Development course, and were administered the quiz halfway through the semester, when they had covered material relating to infancy, childhood, and adolescence, but before the introduction of material on adulthood and aging. The two other groups of students were in third year: one group (n=83), composed primarily of students majoring in Child Studies, were tested in the last week of a course on Parent-Child Relations which dealt in part with issues of older parent—adult child interaction[3]; the other group (n=64) were students in the final week of a course entitled Introduction to Gerontology, and were primarily Family Studies majors. The faculty group (n=27 consisted of members of the applied, multidisciplinary Department of Family Studies and included faculty teaching in the applied human nutrition, child, and family studies areas. The public health nurses (n=153 represent a non-academic professional population. All are community health nurses and vary in the proportion of elderly clients in their caseloads.

These samples were selected to provide a comparison between students at varying levels of learning with respect to gerontology, and between these students and two professional groupings, one academic and the other not. Because gerontology is part of the Department of Family Studies' teaching and research activities, we might reasonably assume that the faculty would score better on the quiz than would the students. Similarly, because the nurses have geriatric patients as part of their caseloads and in varying degrees have encountered gerontology as part of their education, they too might be expected to score higher than introductory-level undergraduates.

Apart from substituting the term "Canadian" for "United States" in statement 19, the format was exactly the same as for Palmore's (1977) original Facts on Aging Quiz. The documentation provided above indicates that no changes in scoring were necessary.

Results and Discussion:

In analyzing our findings, we chose to use descriptive statistics that would clarify the usefulness of the quiz as a test of knowledge and a means of assessing common misconceptions about aging and old age. Thus, we examined the percentage of response error for each group on each item, as well as their mean scores on the full quiz. In addition, we compared our findings to those of previous investigators.

Percentage Error. Table I summarizes the findings of our testing on the undergraduate,

TABLE 1

Percentage Error by Group Means

	Undergraduate				
	Intro. Human Development	Child Studies	Social Geron-tology	Faculty	Nurses
1. The majority of old people (past age 65) are senile (i.e. defective memory, disoriented, or demented).	2	1	0	0	1
2. All five senses tend to decline in old age.	40	47	5	56	43
3. Most old people have no interest in, or capacity for, sexual relations.	7	4	0	0	3
4. Lung capacity tends to decline in old age.	46	27	17	22	41
5. The majority of old people feel miserable most of the time.	5	2	0	0	1
6. Physical strength tends to decline in old age.	3	5	2	4	13
7. At least one-tenth of the aged are living in long-stay institutions (i.e. nursing homes, mental hospitals, homes for the aged, etc.).	73	71	22	41	57
8. Aged drivers have fewer accidents per person than drivers under age 65.	38	28	45	33	31
9. Most older workers cannot work as effectively as younger workers.	24	18	17	11	8
10. About 80% of the aged are healthy enough to carry out their normal activities.	11	12	8	4	9
11. Most old people are set in their ways and unable to change.	48	31	14	18	23
12. Old people usually take longer to learn something new.	47	46	23	26	49
13. It is almost impossible for most old people to learn new things.	2	1	0	0	2

	Undergraduate				
	Intro. Human Development	Child Studies	Social Gerontology	Faculty	Nurses
14. The reaction time of most old people tends to be slower than reaction time of younger people.	9	7	2	4	10
15. In general, most old people are pretty much alike.	8	0	0	4	3
16. The majority of old people are seldom bored.	75	61	42	44	55
17. The majority of old people are socially isolated and lonely.	38	24	16	18	33
18. Older workers have fewer accidents than younger workers.	46	40	39	37	34
19. Over 15% of the Canadian population are now age 65 or over.	84	86	9	70	82
20. Most medical practitioners tend to give low priority to the aged.	60	44	12	33	27
21. The majority of older people have incomes below the poverty level (as defined by the Federal Government).	72	66	77	48	77
22. The majority of old people are working or would like to have some kind of work to do (including housework and volunteer work).	11	16	30	4	18
23. Older people tend to become more religious as they age.	50	34	25	59	43
24. The majority of old people are seldom irritated or angry.	73	70	58	67	67
25. The health and socioeconomic status of older people (compared to younger people) in the year 2000 will probably be about the same as now.	17	46	45	33	26
N =	258	83	64	27	153
x incorrect	8.9	7.9	5.1	6.6	7.6
Std. Dev.	2.7	2.8	2.4	2.6	2.9

faculty, and nursing groups, and presents the percentage error by group means for each quiz item. One striking feature of these findings lies in the overall consistency of item scores between our sample and comparable groups reported in the literature. Palmore (1980), in summarizing the findings of other quiz users, has noted that quiz items 7, 11, 16, 19, 21, and 24 are the ones most frequently scored incorrectly. This is generally true of our sample as well. For example, 73 percent of our first-year undergraduates, 74 percent of Palmore's (1977), 72 percent of Miller and Dodder's (1980) and 86 percent of those reported by Luszcz (1982) scored item 7 incorrectly. Similarly, 44 percent of both our faculty group and 55 percent of that of Palmore (1977) scored item 16 incorrectly.

However, while there was general consistency in the ordering of items by percentage error, there were some differences. The Guelph respondents frequently answered item 2 incorrectly. Large minorities in four of our five groups wrongly indicated that the five senses do not decline in old age. As well, we may have an explanation for the high frequency of incorrect responses on items 7 and 21 which does not reflect on the knowledge of the respondents. Our documentation on rates of institutionalization (7) and income levels of elderly persons (21) indicate that the Canadian context is difficult to characterize. Perhaps our participants were responding to this complexity. Overall then, the Guelph samples were quite comparable to samples reported in other studies in terms of the most common misconceptions about aging: they typically were misinformed about the proportion of the aged population in long-term care facilities, the inflexibility of the aged, the boredom of old age, the proportion of the population over age 65, the financial status of the aged, and patterns of irritability among the aged. Other common misconceptions involve the decline in senses and lung capacity, and the religiosity of the aged.

Mean Scores. An examination of Table II also suggests patterns of variation in sample means and indicates, in general terms, how the Guelph samples compare internationally.

Many of the samples tested to date have included college or university students. This is true of our study as it is of Palmore (1977), Holtzman and Beck (1979), Miller and Dodder (1980), and Luszcz (1982). On occasion, community adults have been surveyed (Romeis & Sussman, 1982; Klemmack, 1978), and also faculty, as in our study and that of Palmore (1977). The inclusion of nurses in our research and that of dentists and nurses in Holtzman and Beck's (1979) study are, to the best of our knowledge, the only community professional groups to be surveyed.

Generally, community adult samples score least well. Their scores are improved on by undergraduate students and then again by graduate students and faculty. Our results differ somewhat from those of Palmore in that faculty were his highest scoring group. In the Guelph study, undergraduates just completing a course in social gerontology held the first position. As with students, clearly the academic interests of faculty will affect their score. We have noted the interdisciplinary character of the Guelph faculty and it might be added that none of those surveyed noted gerontology as a primary interest. It is not known what the interest areas of Palmore's 11 faculty members were.

In Holtzman and Beck (1979), the nurses rank between random community samples and the university undergraduates. By contrast, in our study, the nurses scored lower than the social gerontology students, but higher than the first year and Child Studies students; in fact, they scored even higher ($x=17.4$) than did the nurses surveyed by Holtzman and Beck ($x=16.2$). Similarly, the overall mean was higher for our sample ($x=17.8$) than it was for Holtzman and Beck's sample ($x=15.6$). This suggests that

TABLE 2
Group Differences in Cross Nation Means

Groups	N	Mean Age	Mean Score	Std. Dev.
Guelph, 1983				
Intro. Human Development	258	19.9	16.11	2.73
Child Studies	83	22.0	17.04	2.85
Social Gerontology	64	22.6	19.92	2.37
Faculty	27	37.3	18.44	2.62
Nurses	153	—	17.43	2.87
Palmore, 1977				
Undergraduates	87	—	16.25	11.2
Graduates	44	—	20.00	7.5
Faculty	11	—	22.50	7.7
Miller & Dodder, 1980				
Undergraduates				
-Palmore version	207	18.5	14.40	—
-Miller & Dodder revisions	223	18.5	15.83	—
Luszcz, 1982				
Australian undergraduates				
3rd yr. undergraduates	52	27	16.00	—
1st yr. undergraduates	166	22	14.50	—
Romeis & Sussman, 1982				
U.S. adults	206	—	13.72	—
Japanese adults	591	—	13.26	—
Klemmack, 1978				
U.S. adults	202	40.2	14.25	—
Holtzman & Beck, 1979				
Dental Students	161	—	16.0	2.2
Medical Students	123	—	17.6	2.4
Registered Nurses	70	—	16.2	2.6
Aides/Orderlies	45	—	13.8	2.9
Dental Assistants	35	—	15.0	2.1
Technicians	34	—	15.2	2.4
Licensed Practical Nurses	30	—	15.3	2.2
Other	16	—	16.0	3.4
TOTAL	511	28.3	—	—

the Facts on Aging Quiz is sensitive to differences in overall knowledge levels. Along with general knowledge, there would seem to be a probability of specific gerontological knowledge increasing in parallel with advances at the general level.

In terms of group differences among the Guelph mean scores, the introductory human development students scored significantly lower ($p<.05$) than the social gerontology students, the faculty or the nurses. Insofar as the human development students are experientially the most junior sample, this result is as one would expect. The social gerontology students have the highest mean score and both the child studies students and the nurses scored significantly ($p<.05$) lower than the gerontology students.

Summary and Conclusions:

The purpose of this paper has been to provide Canadian documentation for the demographic items in Palmore's original Facts on Aging Quiz (1977) and to add a Canadian example to the cross-cultural literature pertaining to the quiz.

The demographic documentation makes the point that if one allows for changes relating to the rate of institutionalization item and the question on income levels and poverty, the test is suitable for a Canadian population.

Our comparison of sample differences within the Guelph group and between the respondents of our study and those of other international studies, indicates the quiz is useful in identifying differences in knowledge levels. Our two principle findings support such a conclusion. First, the items most frequently answered incorrectly by the Guelph samples are generally those reported elsewhere in the literature as poorly done. Second, the differences in overall mean score varied as expected in direct relation to specific gerontological education and experience.

Thus, our analysis indicates that the Facts on Aging Quiz is a useful way to fulfill, in the Canadian context, two of the pedagogical objectives identified by Palmore: to measure overall levels of information, and to identify misconceptions about aging. As well, in our teaching all of us have found it valuable in stimulating discussion—another of Palmore's objectives for the test. Nevertheless, two troublesome issues remain. The first concerns the ability of the quiz to assess age bias; the second relates to the validity of the measure as a research tool, a function which Palmore did not have in mind, but one which is becoming increasingly more frequent. Neither of these issues has been addressed satisfactorily in past research.

FOOTNOTES

1. From findings reported in summary form by Palmore (1980), we do know that the quiz has been used previously in Canada.
2. These figures report income distributions in Canada in 1979, and are included here because the data were reported by Statistics Canada in 1981, and hence would have been the most up-to-date figures available at that time that some of the earlier respondents were administered the quiz. At that time, the low-income cut-off was based on a 1969 tabulation derived from the Consumer Price Index. The low income cut-off was, however, subsequently revised on the basis of 1978 Family Expenditure data, with low income families on average spending 58.5% of their income on food, clothing and shelter. Based on this calculation, the 1981 incidence of low income among the aged changes to 14.5% among families with heads aged 65 and over, and to 66.3% among unattached individuals aged 65 and over. (Statistics Canada, 1983).
3. The third year students in Parent-Child Relations had taken the Human Development course approximately two years earlier, and had therefore had some introduction to aging in a lifespan context. This component of the course involves only three weeks of lectures, however, and provides an overview of biological, psychological, social and economic aspects of aging.
4. There is no ready explanation for why the social gerontology students, with the overall highest

mean correct, had the highest error rates for items 8 and 22. It may be that they had more information than did most of the other groups on age-related physical decrements, and extrapolated incorrectly on the basis of this. The nurses, with even more knowledge of such changes, may have based their answers on more experience with the aged, thus having a lower percentage error on this item.

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RESUMÉ

Le "*Facts on Aging Quiz*" (Questionnaire sur les faits du vieillissement) élabore par Erdman Palmore constitue un examen bref, sûr et facile a administrer, largement utilise en vue de savcir dans quelle mesure les sujets connaissent les faits concernant le vieillissement. Le present article porte sur l'applicabilité de ce questionnaire au contexte canadien et fournit de la documentation sur certains item. On y note les problèmes d'interpretation que peuvent soulever les item visant le taux d'institutionnalisation et le niveau de vie. On y compare aussi les connaissances et les domaines mal connus parmi un échantillonnage (n = 585) comprenant des etudiants du premier cycle, des professeurs d'université et des professionnels de la sante. Les resultats confirment l'utilité du questionnaire pour apprécier la diversite des niveaux d'information.

APPENDIX "C"

An alternate form of the Facts on Aging Quiz is presented and documented. Pilot tests indicate that it is useful for stimulating discussion and clarifying other misconceptions about aging; for identifying frequent misconceptions; for measuring bias; and for measuring the effects of educational experiences in gerontology.

The Facts on Aging Quiz: Part Two[1]

Erdman B. Palmore, PhD[2]

The first Facts on Aging Quiz (Palmore, 1977) has been widely used for several purposes: stimulating group discussion and clarification of misconceptions; measuring and comparing different groups' levels of information about aging; identifying the most frequent misconceptions about aging; measuring bias toward the aged; and measuring the effects of courses and workshops. Results of over forty studies using the FAQ have been reported (Brubaker & Barresi, 1979; Holtzman & Beck, 1979; Klemmack, 1978; Miller & Dodder, 1980; Palmore, 1978, 1980). Its validity and reliability have been discussed and documented (Palmore, 1978, 1980). A videotape series has been produced on the FAQ (Courtenay & Suhart, 1980). It remains the only published test of knowledge about aging which is both short and documented by research findings.

An alternate form of the FAQ can be useful for several of the above purposes: it can be used to stimulate discussion and clarify other misconceptions in groups that are familiar with the first form; it can identify the most frequent misconceptions about other facts on aging; it can indirectly measure bias; and in test-retest situations it can more accurately measure the effects of courses and workshops by avoiding the "practice effects" of using the first form twice. It may also be used at the same time as the first form for a more comprehensive coverage of the basic facts on aging. For these purposes an alternate form of the FAQ is presented below. These items, like the first set, are designed to deal with basic physical, psychological, and social facts on aging. You are encouraged to try out the quiz on yourself, before reading further, in order to find out which of these facts you may be unaware of. Mark the items "T" for True or "F" for False.

1. A person's height tends to decline in old age.
2. More older persons (over 65) have chronic illnesses that limit their activity than younger persons.
3. Older persons have more acute (short-term) illnesses than persons under 65.
4. Older persons have more injuries in the home than persons under 65.
5. Older workers have less absenteeism than younger workers.
6. The life expectancy of Blacks at age 65 is about the same as Whites.
7. The life expectancy of men at age 65 is about the same as women's.
8. Medicare pays over half of the medical expenses for the aged.
9. Social Security benefits automatically increase with inflation.
10. Supplemental Security Income guarantees a minimum income for needy aged.
11. The aged do not get their proportionate share (about 11%) of the nation's income.
12. The aged have higher rates of criminal victimization than persons under 65.
13. The aged are more fearful of crime than are persons under 65.
14. The aged are the most law abiding of all adult groups according to official statistics.
15. There are two widows for each widower among the aged.
16. More of the aged vote than any other age group.
17. There are proportionately more older persons in public office than in the total population.
18. The proportion of Blacks among the aged is growing.

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19. Participation in voluntary organizations (churches and clubs) tends to decline among the healthy aged.
20. The majority of aged live alone.
21. About 3% more of the aged have incomes below the official poverty level than the rest of the population.
22. The rate of poverty among aged Blacks is about 3 times as high as among aged Whites.
23. Older persons who reduce their activity tend to be happier than those who remain active.
24. When the last child leaves home, the majority of parents have serious problems adjusting to their "empty nest."
25. The proportion widowed is decreasing among the aged.

The key to the correct answers is simple: alternating pairs of items are true or false (i.e., 1 & 2 are true, 3 & 4 are false, 5 & 6 are true, etc., and 25 is true).

Documentation

1. Height does tend to decline with age. Cross-sectional studies of 35 different populations around the world all show that persons in each decade of life over age 50 are shorter than the persons in the previous decade (Rossman, 1977). Some of these differences are due to cohort differences because later cohorts have tended to be taller than earlier cohorts, presumably because of improved environmental conditions such as nutrition. However, all the longitudinal studies (which repeatedly measure the same cohort over many years) also show decreases in average height after age 55. This decrease in height appears to be mainly caused by changes in posture or "slump" and by decreases in the intervertebral discs.

2. More persons over 65 have chronic illnesses that limit their activity (43%) than younger persons (10%). The discrepancy is even greater for the percentage with chronic illnesses that limit their major activity: 37% of those over 65 compared to only 7% of those under 65 (National Center for Health Statistics, 1978).

3. On the other hand, older persons have less acute illnesses than younger persons: there are 102 acute illnesses per 100 persons over age 65 per year, compared to 230 for persons under 65 (National Ctr. for Health Statistics, 1978). Thus, the higher rate of chronic illnesses among the aged is partially offset by the lower rate of acute illnesses.

4. Furthermore, older persons have less injuries in the home than younger persons: 12.5 per 100 persons over 65 per year compared to 14 for persons under 65 (National Ctr. for Health Statistics, 1978). The injury rate is especially high for children under 6: 26 per 100.

5. Older workers do have less absenteeism than younger workers (Kossoris, 1948; Mark, 1957). Among men in manufacturing plants, absenteeism is about the same for those over 65 as for those 35 to 64 (3.2 days per 100), but absenteeism is higher among those under age 35 (4.2 days per 100).

6. The life expectancy of Blacks at age 65 is about the same as Whites'. In 1978 the average life expectancy at age 65 was 14.0 for White men and 14.1 for non-white men; 18.4 for White women and 18.0 for non-white women. (Life expectancy data have not been available for Blacks separately since 1970, but since Blacks constitute about 90% of non-whites, there is little difference between the life expectancies of Blacks and all non-whites. For example, in 1970 the difference was less than one-half year at age 65.) (National Ctr. for Health Statistics, 1980).

7. The life expectancy of men at age 65 continues to be substantially less than that of women, just as it is at all ages. In 1978, the life expectancy of men at age 65 was 14 years while that of women was 18.4 years. Thus, women at that age can expect to live 4.4 years more than men (National Ctr. for Health Statistics, 1980).

8. Medicare pays less than half of the medical expenses for the aged. In 1977, Medicare payments covered 44% of the personal health care expenditures of the aged (Gibson & Fisher, 1979). Medicaid covered an additional 17% (among the "medically indigent"), other public programs (such as the Veteran's Administration) covered another 6%, and the remaining 33% was paid by private insurance or "out-of-pocket."

9. Social Security benefits do automatically increase with inflation. Since 1975 Social Security benefits have been automatically increased whenever the Consumer Price Index (CPI) of the Bureau of Labor Statistics for the first calendar quarter of a year exceeds by at least 3% the CPI for the first calendar quarter of the preceding year. The size of the benefit increase is determined by the actual percentage rise of the CPI during the quarters measured. For example, in June 1980, the Social Security benefits increased by 14.3%.

10. Supplemental Security Income does guarantee a minimum income for needy aged. In January, 1974, the Supplemental Security Income (SSI) program was established to provide a minimum monthly income for all persons over 65 with assets of less than a stated amount ($1,500 for an individual, $2,250 for a couple), excluding the value of a home, household goods, personal effects, an automobile, life insurance of less than $1,500, and property needed for self-support. In January, 1981, persons over 65 could receive monthly SSI payments of up to $238 for an individual or $357 for a couple.

11. The aged do get their proportionate share of the nation's income. In 1967 the aged's share of the nation's total personal income before taxes was about 10% and they constituted slightly less than 10% of the total population (Bixby, 1970). In 1973 the aged received 11.2% of aggregate household money income before taxes, and they constituted 10.4% of the total population (U.S. Bureau of Census, 1974). If taxes and transfer payments are taken into account, the aged receive *more* than their proportionate share of the total personal income: in 1972 persons age 65 and over received 13.7% of total income after taxes were deducted and transfer payments added (Fried et al., 1973).

12. The aged actually have lower rates of criminal victimization than those under 65. Persons over 65 have substantially lower victimization rates in nearly all categories of personal crime: rape, robbery, assault, and personal theft (U.S. Dept. of Justice, 1977). The only category in which the rate for older persons is even equal that of younger persons is "personal larceny with contact" (which includes purse-snatching and pick-pocketing) and this category accounts for less than 3% of all personal crimes. When all personal crimes are added together, persons over 65 have a victimization rate that is less than one-fourth that of all persons over age 12 (31 per 1,000 compared to 128 per 1,000).

13. The aged are more fearful of crime, despite their lower rates of victimization. In a nationally representative survey, 23% of those over 65 said that fear of crime was a "very serious problem" for them compared to 15% of those 18-64 (Harris, 1975). Another national survey found that 51% of those 65 and over compared to 41% of those under 65 answered "yes" to the question, "Is there any area right around here where you would be afraid to walk alone at night?" (Clemente & Kleinman, 1976). Women, Blacks, and metropolitan aged have especially high proportions fearful of crime. This greater fear of crime among the aged may be one reason their actual victimization rate is lower.

14. The aged are the most law abiding of all adult groups regardless of how it is measured. For example, persons over 65 have about one-tenth their expected arrest rate for all offenses (arrests of persons 65+ are 1.2% of the total arrests) and about one-twentieth their expected rate for felony offenses (65+ are .5% of the total) (Federal Bureau of Investigation, 1974). Similarly, persons over 65 are incarcerated in prisons and jails at about one-tenth their expected rate (65+ are 1.3% of all prisoners) (U.S. Bureau of Census, 1973).

15. There are not just two widows for each widower. Instead there are over five times as many widows as widowers among the aged. In 1978 there were about 6,917,000 widows 65 and over compared to 1,300,000 widowers 65 and over (U.S. Bureau of Census, 1979).

16. Less of the aged vote than do middle-aged groups. Numerous cross-sectional studies have shown that voting participation increases with age from the 20s to the early 60s and then falls off after age 65 (Hudson & Binstock, 1976). A cross-national study found the same pattern in the United States, Austria, India, Japan, and Nigeria (Nie et al., 1974). However, the lower voting participation of the aged is not due to aging processes, but to the larger proportions of the aged who are female and have less education (Glenn & Grimes, 1968; Houte & Knoke, 1975; Verba & Nie, 1972).

17. There are proportionately more older persons in public office than in the total population. This appears to be true of all pubic officials and is even more true of the higher officials. In 44% of the years in which we have had a President, the President was over age 60, and in 14% the President was over age 65 (Metropolitan Statistical Bulletin, 1980). In 1975, 21% of U.S. Representatives and 39% of U.S. Senators were 60 or over (U.S. Bureau of Census, 1976), compared to 15% of the total population being 60 or over. Older persons are also over represented among U.S. ambassadors, Supreme Court justices, cabinet members, and Governers (Lehman, 1953; Schlesinger, 1966).

18. The proportion of Blacks among the aged is growing. In 1960, Blacks were 7.1% of all persons 65 or over, in 1980 they were 8.3%, and it is estimated that in year 2000 they will be 9.5% (Williams, 1980).

19. Participation in voluntary organizations does not usually decline with age among healthy older persons. A number of recent nationwide surveys have shown that when the effects of socioeconomic differences and health are controlled, age bears little or no relationship to voluntary association participation in middle age or later life (Cutler, 1977). In longitudinal studies persons with either increased or stable participation far outnumbered those whose participation declined. However declining health does tend to decrease participation.

20. The majority of aged do not live alone. In 1975 for example, only 14.2% of men 65 or over lived alone, and 36.0% of women 65 or over lived alone (Siegel, 1976). The majority lived with their spouse (74% of men, 36% of women, 51% of the total 65 or over).

21. About 3% more of the aged have incomes below the official poverty level than the rest of the population. In 1978, 14% of persons 65 or over had incomes below the official government poverty thresholds ($3,157 for an individual and $3,947 for a couple 65+) compared to 11.4% for all persons (U.S. Bureau of Census, 1980). This is a decline from 35% of the aged in 1959.

22. The rate of poverty among aged Blacks is about 3 times as high as among whites. In 1978 the rate of poverty among Blacks 65 or over was 34% compared to 12% for whites (U.S. Bureau of Census, 1980).

23. Older persons who disengage from active roles do not tend to be happier than those who remain active. On the contrary, most surveys and longitudinal studies have found that those who remain active tend to be happier than those who disengage, although some studies found no relationship between activity and happiness. For example, several studies have found no over-all relation between retirement and morale or life satisfaction (George & Maddox, 1977; Simpson & McKinney, 1966; Streib & Schneider, 1971). On the other hand, the Duke Second Longitudinal Study found small declines in life satisfaction and happiness after retirement (Palmore et al., 1979). A review of 17 studies of activity and life satisfaction showed that most studies found significant positive relationships between more activity and greater life satisfaction, although a few of the relationships were not statistically significant (Larson, 1978).

24. When the last child leaves home, the majority of parents do not have serious problems adjusting to their "empty nest." Glenn (1975) concluded from his study that the last child leaving home does not typically have an enduring negative effect. Our longitudinal study also found no lasting negative effects of the last child leaving home, and instead found two significant positive effects: life satisfaction and happiness both increased significantly after the last child left home (Palmore et al., 1979).

25. The proportion widowed is decreasing among the aged because of decreasing mortality rates. In 1950, 40.1% of those 65 or over were widowed; in 1960, 37.2%; and in 1978, 36.6% were widowed (U.S. Bureau of Census, 1979). Apparently, increasing longevity increases the average age at widowhood and thus increases the proportion of years beyond age 65 in which the couple survives as a couple.

Uses

As with the first Facts on Aging Quiz, the second FAQ never fails to stimulate much discussion because most people are amazed at many of these facts. Since the quiz is designed to be self-scored, participants get immediate feed-back on their misconceptions, which can be corrected by presentation and discussion of the correct facts.

When we tested out the Facts on Aging Quiz, Part 2 (FAQ2) on various groups of students, staff, and faculty at Duke Univ. ($N = 114$) and at a workshop on aging ($N = 28$) we found that there are nine frequent misconceptions: facts which one-half or more of the participants did not know (Table 1). Actually, more than one-half probably did not know these facts since many merely guessed at the right answer. In true-false statements, one has a 50% chance of guessing correctly. In order of frequency, these misconceptions were: 85% thought there were only two widows for each widower rather than five (#15); 80% thought the aged have higher rates of victimization (#12); 77% thought the life expectancy of blacks at age 65 is different from whites; 73% did not know that Social Security benefits automatically increase with inflation; 69% did not know that Supplemental Security Income guarantees a minimum income to needy aged; 58% thought that when the last child leaves home, the majority of parents have serious problems adjusting to their "empty nest"; 53% thought the majority of aged live alone; and 50% thought older persons have more injuries in the home than persons under 65.

Table 1. Facts on Aging Quiz, Part 2, Percent Correct by Fact.

Fact	% Correct
1. Height declines.	85
2. More chronic illness.	79
3. Less acute illness.	51
4. Less injuries in the home.	50
5. Less absenteeism.	83
6. Life expectancy same for Blacks and Whites	23
7. Life expectancy of women greater than men's.	92
8. Medicare pays less than half of medical expenses.	52
9. Social Security benefits increase with inflation.	27
10. Guaranteed minimum income	31
11. Aged get proportionate share of income.	20
12. Lower rates of criminal victimization.	20
13. More fearful of crime.	85
14. Most law abiding.	85
15. 5 widows for each widower.	15
16. Aged vote less.	53
17. More in public office.	55
18. Proportion of Blacks growing.	85
19. Participation in voluntary organizations stable.	72
20. Majority live with others.	42
21. 3% more aged in poverty.	82
22. Poverty rate among Blacks is 3 times that of Whites.	89
23. Disengaged less happy than active.	95
24. "Empty nest" not cause serious problems.	42
25. Proportion widowed is decreasing.	63
Mean	59

The fact that seven of these nine frequent misconceptions involve negative stereotypes of the aged (poverty, injuries, criminal victimization, living alone, loneliness from children leaving home) confirms the finding from the first FAQ that most of the frequent misconceptions represent negative views of old age.

Another use of the FAQ is as an indirect measure of bias toward the aged. Errors on some items probably indicate a negative bias toward the aged. For example, if someone says it is true that older persons have more acute illnesses than younger persons (#3) it probably reflects a negative (sick) image of the aged. On the other hand, errors on other items probably indicate a positive bias toward the aged. For example, if someone denies that more older persons have chronic illnesses (#2), it probably indicates an unrealistically favorable image of the aged. We have classified 14 items as indicating a negative bias toward the aged if they are marked incorrectly: #3, 4, 5, 9, 10, 11, 12, 14, 17, 19, 20, 21, 24, and 25. On the other hand, we have classified five items as indicating a negative bias if they are marked incorrectly: #1, 2, 8, 13, and 16. Using these items, one can then compute a net bias score by subtracting the percentage of errors on the negative bias items from the percentage of errors on the positive bias items. Note that subtracting *percentages* rather than raw numbers controls for the fact that there are more negative bias items than positive. If the resulting score is negative, it indicates a net anti-aged bias; if it is positive, it indicates a net pro-aged bias. In our pilot tests of FAQ2 (N = 142), we found an average of 48% errors on the negative items and 29% errors on the positive items. Thus, there was an average of 19% net anti-aged bias in these groups. This is somewhat higher than the net anti-aged bias of 5% we found in these groups using the first form of the FAQ, but it tends to support the findings of several previous studies that the average person has more anti-aged than pro-aged bias. I have concluded (Palmore, 1980) that this is not the best way of measuring bias toward the aged because it is only an indirect measure, but it can be used as a rough indicator in the absense of one of the more direct measures.

The final use of the two forms of the FAQ is as a measure of the effects of lectures, courses, or other training experiences by comparing scores on one form given before the experience with scores on the other form given after the experience. The advantage of using alternate forms, rather than the same form twice, is that alternate forms avoid the bias of practice effects. The average correlation of the first form with the second was .50 (with groups equally weighted). Groups which knew more about aging, such as graduate students and staff at the Center on Aging and Human Development, had higher correlations (.70 to .80). However, we found that all these groups got higher scores (% correct) on the first form than on the second. This discrepancy ranged from an average of five percentage points for persons untrained in gerontology (FAQ1 = 67%; FAQ2 = 62%) to a discrepancy of 26 for persons with some training in gerontology (FAQ1 = 84%; FAQ2 = 58%). Apparently those with some training in gerontology learned some of the facts in the first form but few of those in the second form. This is understandable because the first form has been widely

used here at the Duke Center, as well as elsewhere, so gerontology students and staff are more likely to be more familiar with the facts in the first form. However, since even the untrained groups scored about five percentage points higher on the first than the second form, I recommend that when the two forms are used to measure learning about the facts on aging, five percentage points (which is about equal to one item of the 25) should be added to the FAQ2 scores to equalize the expected scores on the two forms.

Validity and Reliability

The primary evidence for the validity of FAQ2 (like that of FAQ1) are the statistics and studies cited in the first part of this article. These statistics come from nationally representative studies or have been confirmed by several local studies, so we can be fairly certain of their validity.

Reliability between the two forms is fairly satisfactory based on the correlations ranging from .50 to .80. However, inter-item correlations tend to be low because the items represent many different dimensions of knowledge about aging (physical, psychological, attitudinal, economic, social, etc.). Apparently, what most people know about aging on one dimension has little correlation with what they know on other dimensions. The inter-item reliability could be improved by limiting the quiz to one dimension and adding items that are similar to each other, but this would eliminate one of the main features of the quizzes: their comprehensiveness.

As I pointed out in response to criticism of the reliability of the first quiz (Palmore, 1978), the usual tests for reliability (such as item-to-total correlations and item discriminatory power) are inappropriate for these quizzes because their primary purpose is "edumetric" (they are designed to yield measurements that are directly interpretable in terms of specified performance standards) rather than "psychometric" (they are not designed to place a person relative to a normative group on a relatively stable trait such as intelligence: Carver, 1974). Thus, attempts to improve the psychometric qualities of the quizzes would tend to interfere with their edumetric purposes: stimulating discussion, identifying most frequent misconceptions, measuring levels of information and changes in these levels — quickly and simply.

Summary

A second form of the Facts on Aging Quiz is presented to supplement the first form. Pilot studies show that it is useful for stimulating discussion and clarifying other misconceptions in groups that are familiar with the first form; for identifying the most frequent misconceptions about other facts on aging; for indirectly measuring bias based on these misconceptions; and for measuring the effects of educational experiences without the practice effects of using the first form twice. All the items are documented with statistics from national studies or several local studies. Seven of the nine most frequent misconceptions involve negative stereotypes. There was an average of 19% net anti-aged bias. Correlations between the two forms ranged from .50 for untrained groups to .80 for groups with some gerontology training. However, it was recommended that five percentage points be added to the scores of the second form to equate it with the scores from the first form. The validity of the quiz rests on the validity of the statistics on which it is based. Item-to-total correlations are low because of the many dimensions measured, but the usual criteria for psychometric test evaluation are inappropriate for edumetric tests such as these quizzes.

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SESSION THREE

THE FACT AND THE FICTION

OBJECTIVE

THIS SESSION WILL CHALLENGE YOUR ASSUMPTION ABOUT THE POTENTIAL OF AGING PEOPLE.

THE LAST OF LIFE (1978) FILM, CBC - THE NATURE OF THINGS. 28 MINUTES (COLOR) AVAILABLE FROM THE MEDIA CENTRE AT NO CHARGE 892-6612.

THIS FILM PRESENTS THE PROCESS OF AGING IN A FAIRLY SCIENTIFIC WAY BUT STILL ALLOWS FOR AN EXPLORATION OF THE POTENTIAL OF THE OLDER PERSON. THE MESSAGE IS VERY POSITIVE AND IT PRESENTS THE MYTHS ABOUT AGING AND PROCEEDS TO DEBUNK THEM.

BEFORE THE FILM: ASK WHAT PEOPLE ASSOCIATE WITH OLD AGE. IF YOU HAVE A BLACKBOARD, PUT THEM DOWN IN PHRASES. THEN SHOW THE FILM.

AFTER THE FILM: ASK THAT PEOPLE JOT DOWN ON A PIECE OF PAPER SOME OF THE IMAGES AND SOUNDS THEY RECALL (5 MINUTES). ASK THEM TO SHARE THIS LIST WITH SOMEONE ELSE FOR A FEW MINUTES. LEAD OFF THE DISCUSSION WITH SOME QUESTIONS LIKE:

A) HOW DO YOU FEEL ABOUT AGING NOW?

B) WHAT SORT OF MYTHS AND STEREOTYPES DID YOU IDENTIFY IN THE FILM AS YOUR OWN?

C) WILL YOU BEGIN TO SEE THE ELDERLY DIFFERENTLY NOW? WHY?

WELLNESS AND AGING _ 15-MINUTE VIDEO (COLOR) AVAILABLE FROM EDUCATIONAL PROGRAMS ON AGING (EPA) HOME CARE AND SUPPORT, HEALTH AND SOCIAL SERVICES, CHARLOTTETOWN, 892-5471.

WELLNESS AND AGING FEATURES MAGGIE KUHN OF THE GRAY PANTHERS WHO EXAMINES INDIVIDUAL AND SOCIETAL ATTITUDES TOWARD THE AGED WHILE DISCUSSING:

SIX NEGATIVE STEREOTYPES ABOUT THE AGED.

AND

WHAT CAN BE DONE TO INCREASE THE WELLNESS OF THE AGED.

THE FOLLOWING IS THE DISCUSSION GUIDE THAT IS PROVIDED ALONG WITH THE TAPE. TAKE WHAT YOU NEED FROM IT AND LEAVE THE REST.

S E S S I O N T H R E E

DISCUSSION GUIDE FOR WELLNESS AND AGING

Description: Maggie Kuhn of the Gray Panthers examines individual and societal attitudes while discussing:

1) six negative stereotypes about the aged and aging in America, and

2) what can be done to increase wellness of the aged.

Intended Audience: Senior Citizens' Groups
Health Professionals, Paraprofessionals, and Students
Sociologists, Gerontologists, Public Policy Planners

Sybject Classification: Gerontology, Growth and Development, Aging, Health and Social Change.

Purpose: To stimulate productive behavior of groups and individuals dealing with the elderly and their self-concept.

Objectives: After viewing this program, the participant will be able to:

1) Discuss the negative stereotypes which influence the public's view of the elderly.

2) Discuss strategies to alleviate the consequences of these stereotypes.

Outline of Videotape:

1) Gerontophobia is defined as the fear and hatred of old people and of growing old. (1)

2) Six Myths (Stereotypes) of Aging:

i Old Age is a DISEASE
ii Old Age is MINDLESS
iii Old Age is SEXLESS
iv Old Age is USELESS
v Old Age is POWERLESS
vi All Old People are ALIKE

3) Prescriptions for Wellness:

   i Organize

   ii Self Criticism and Criticism of Our Society

   iii Continuing Education

   iv Legislation: specifically, the Dellums bill to create a National Health Service, H.R. 2969

4) Maggie Kuhn's personal discoveries about aging.

DISCUSSION TOPICS FOR WELLNESS AND AGING

1) Give an example of gerontophobia you or someone you know has experienced.

2) Discuss how literature and/or the mass media portray senior citizens.

3) Describe a community program designed to aid the elderly. Discuss its failures and/or accomplishments.

4) How does an elderly person's diet effect his/her physical and mental health?

5) America's uniuqe focus upon the individual has contributed to the loss of "a sense of community." What implications does this have for the elderly in our society?

6) Cultures relate to the elderly in different ways. Describe one cultural view and contrast it to another.

7) Compare the terms geriatrics and gerontology.

8) The percentage of our population which is over sixty-five is increasing. What are some of the positive aspects for our society related to this shift?

9) Think about yourself being elderly. How does this make you feel?

10) What is WELLNESS? In what way is our present medical system wellness oriented?

11) Take a position and defend it in regard to the following statement: "Wellness in Aging is achievable in American Society."

SUGGESTED READINGS AND FOOTNOTE

1) Crandall, Richard C., 1980 Gerontology, A Behavioral Science Approach. Addison-Wesley Publishing Company, Inc., p.9.

2) Skeist, Robert J., 1980, To Your Good Health, Chicago Review Press, Chicago.

SESSION FOUR

ISSUES: DRUGS AND NUTRITION

OBJECTIVE

THIS SESSION WILL PRESENT TWO OF THE MOST IMPORTANT HEALTH ISSUES THAT CONCERN THE ELDERLY: DRUGS AND NUTRITION.

THE TWO VIDEOS FOR THIS SESSION WERE PRODUCED BY THE EDUCATIONAL PROGRAMS ON AGING PROJECT FOR CAREGIVERS AND VOLUNTEERS IN SERVICES TO THE ELDERLY.

FOR THIS SESSION, YOU ARE GOING TO NEED THE ASSISTANCE OF YOUR COMMUNITY DIETICIAN,YOUR PHARMACIST, A PUBLIC HEALTH NURSE OR PROVINCIAL HOMEMAKER TO SERVE ON A PANEL TO RESPOND TO THE VIDEOS AND ELABORATE ON THE ISSUES. CALL THE REGIONAL SERVICES CENTRE AND ASK FOR THE COORDINATOR OF HOME CARE AND SUPPORT SERVICES FOR SOME NAMES OF HOMEMAKERS AND PUBLIC HEALTH NURSES IN YOUR AREA WHO MIGHT BE AVAILABLE TO COME IN AND SPEND PART OF THE EVENING.

VIDEO I - CAN'T YOU GIVE 'EM SOMETHING (16 MINUTES, COLOR) AVAILABLE IN 3/4" V-MATIC, 1/2" VHS, AND 1/2" BETA.

THIS VIDEO PRESENTS KATHLEEN CORR, A FORMER RESIDENT OF SUMMERSET MANOR IN SUMMERSIDE, AS SHE RELATED HOW SHE HAD ENTERED THE MANOR, BEDRIDDEN AND TAKING SOMETHING LIKE TEN PRESCRIPTION DRUGS.

THE MANOR BEGAN A DRUG REDUCTION PROGRAM THAT EVENTUALLY ASSISTED KATHLEEN IN ELIMINATING MOST OF HER DRUG DEPENDENCY. KATHLEEN NOW LIVES ON HER OWN IN AN APARTMENT. SHE IS A WITNESS

TO THE SUCCESS OF DRUG REDUCTION FOR THE ELDERLY. THE VIDEO PRESENTS SOME OF THE REASONS FOR OVER-PRESCRIPTION OF DRUGS TO THE ELDERLY IN A BALANCED WAY THAT ALLOWS FOR GOOD DISCUSSION.

EDUCATIONAL FORMAT

CAN'T YOU GIVE 'EM SOMETHING IS AVAILABLE AS A ONE-HOUR VIDEO TAPE WHICH PRESENTS THE DOCUMENTARY ALONG WITH SEVEN PROBING QUESTIONS AND INSTANT REPLAYS ON THE SCREEN, TIMES TO LAST ONE HOUR. THIS IS "INSTRUCTORLESS EDUCATION." THE QUESTIONS APPEAR ON THE SCREEN AND REMAIN THERE FOR FIVE MINUTES TO ALLOW SOME DISCUSSION; THIS IS FOLLOWED BY SHORT CLIPS OR REPLAYS FROM THE DOCUMENTARY. THE WHOLE THING ALLOWS THE TEACHER/LEADER TO RELAX AND PARTICIPATE IN THE LEARNING EXERCISE ALONG WITH THE PARTICIPANT.

SAMPLE QUESTIONS:

WHAT ARE THE CAUSES OF DRUG OVERUSE?

SHOULD THE ELDERLY THROW AWAY THEIR DRUGS AFTER VIEWING THIS VIDEO?

WHERE DOES THE PRESSURE TO TAKE MORE MEDICINE COME FROM?

VIDEO II - IN A LAND OF PLENTY - THIS VIDEO PRESENTS THE QUESTION OF MALNUTRITION IN THE ELDERLY WHO LIVE IN THE COMMUNITY. THE IRONY OF OLD PEOPLE SUFFERING FROM MALNUTRITION IN A LAND OF PLENTY, AN AGRICULTURAL AND FISHING PROVINCE LIKE PRINCE EDWARD ISLAND, IS EXPLORED IN THIS 12-MINUTE VIDEO DOCUMENTARY.

SOME OF THE CAUSES WHICH ARE PRESENTED ARE OVER-THE-COUNTER MEDICINES; THE TEA-AND-TOAST SYNDROME; INSUFFICIENT CALCIUM INTAKE; AND DIET AND INADEQUATE INCOME.

EDUCATIONAL FORMAT

THIS VIDEO ALSO COMES IN A LARGER FORMAT WITH QUESTIONS ON THE SCREEN FOR DISCUSSION AND INSTANT REPLAYS TO REVIEW THE MESSAGES IN THE DOCUMENTARY.

SAMPLE QUESTIONS:

WHAT ARE THE CAUSES OF MALNUTRITION IN THE ELDERLY?

WHAT IS THE TEA-AND-TOAST SYNDROME?

WHAT ARE SOME OF THE CONSEQUENCES OF POOR NUTRITION IN OLDER PERSONS THAT AFFECT THEIR ROLES IN THE COMMUNITY?

A PHARMACIST MIGHT BE INVITED TO COMMENT ON THE FIRST VIDEO; AND A COMMUNITY NUTRITIONIST OR HOME ECONOMIST MIGHT PROVE TO BE A VERY USEFUL RESOURCE PERSON FOR THE SECOND

SESSION FIVE

RETIREMENT

OBJECTIVE

To examine retirement as a productive time.

The purpose of this session is to present positive images of aging as they appear in the film, **AS WE GROW OLDER**. This film is available from the Division of Aging and Extended Care (Ch'town) at no charge to the user. Phone 892-5471.

METHOD: Questions before the film:

A) What does retirement conjur up in your mind?

B) What images come to mind when you think abour your own retirement?

C) Have you made any decisions about when you will retire or what you intend to do in your retirement? Discuss.

Show the film. The content--there are five short vignettes or stories presented in the film.

A) A retired teacher who lives independently and teaches swimming to children. She presents her philosophy of living as well as her attitude about dying: "God wants me...I'm not afraid." Her philosophy of life is simple: stretch, stretch, stretch.

B) Widow living in a senior apartment who has to be very frugal. She feels that living with her children is not a good option.

C) A RETIRED ARCHITECT WHO MOVED TO A RETIREMENT RESIDENCE OPERATED BY THE "SISTERS." HE HAS FIVE SONS AND SAYS HE NEVER VISITS WITHOUT AN INVITATION. HE SAYS, "I ALWAYS WANT TO BE INVITED FOR DINNER."

D) A BOAT BUILDER WHO IS OBVIOUSLY WELL OFF. HE STARTED A MASSIVE BOAT-BUILDING PROJECT IN HIS RETIREMENT BECAUSE HE HAD BUILT BOATS FOR OTHER PEOPLE MOST OF HIS LIFE.

E) A POOR BLACK COUPLE LIVING FROM "HAND TO MOUTH" AND YET THE WOMEN SAYS, "I ENJOY EVERY DAY, BECAUSE IT MAY BE MY LAST DAY."

THESE STORIES CAN BE THE STUFF OF SOME SPIRITED DISCUSSION.

SOME QUESTIONS AFTER THE FILM:

A) SHOULD THE OLDER PERSON BE ENCOURAGED TO MOVE IN WITH THEIR CHILDREN AND FAMILIES? WHY? OR WHY NOT?

B) IS RETIREMENT PLANNING SOMETHING THAT YOU SHOULD LOOK INTO BEFORE THE END OF YOUR WORK LIFE? DISCUSS.

C) WHAT ABOUT RETIREMENT INCOME? SHOULD OLDER PEOPLE HAVE SOME KIND OF SUBSIDY TO HELP COMPENSATE FOR THE LOSS OF INCOME FROM WORK?

D) SHOULD RETIREMENT BE MANDATORY AT 65 YEARS? WHY? OR WHY NOT?

PART TWO

INVITE THREE RETIRED PEOPLE FROM YOUR COMMUNITY TO COME IN FOR THE EVENING. HAVE THEM COME EARLY ENOUGH TO SEE THE FILM AND TAKE PART IN AN INFORMAL WAY IN THE DISCUSSION.

IN THE SECOND PART OF THE EVENING, HAVE EACH OF THEM PREPARE AND READ A SHORT PARAGRAPH OR STATEMENT ON THEIR OWN RETIREMENT. SOME QUESTIONS YOU MIGHT SUGGEST TO THEM ARE AS FOLLOWS:

A) DID YOU PLAN FOR YOUR OWN RETIREMENT OR DID IT SNEAK UP ON YOU?

B) WERE YOU LOOKING FORWARD TO YOUR RETIREMENT? HOW DO YOU FEEL TODAY?

C) WERE THERE ANY SURPRISES FOR YOU?

INVITE THE GUESTS TO SIT IN THE FRONT OF THE ROOM TOGETHER WITH THE GROUP LEADER. EACH PERSON MIGHT TAKE FIVE MINUTES TO PRESENT HIS/HER STATEMENT, FOLLOWED BY A GENERAL DISCUSSION ON THE ISSUES RAISED.

HERE ARE SOME GENERAL QUESTIONS THAT YOU MIGHT "THROW OUT" TO START THE DISCUSSION:

A) DO RETIRED PEOPLE HAVE AN IMPORTANT ENOUGH ROLE IN THE COMMUNITY?

B) DO RETIRED PEOPLE PREFER TO WITHDRAW FROM THE MAINSTREAM AND BEGIN A LIFE OF LEISURE?

C) ARE THERE RETIRED PEOPLE IN YOUR COMMUNITY WHO HAVE BECOME MORE ACTIVE THAN THEY EVER WERE? HOW DO YOU FEEL ABOUT THEM NOW?

THERE ARE TWO THEORIES ABOUT WHAT HAPPENS TO PEOPLE UPON RETIREMENT. THE FIRST IS THE **"DISENGAGEMENT THEORY"** WHICH SUGGESTS THAT THE PERSON WITHDRAWS FROM THE ACTIVE WORLD AND BEGINS A NEW LIFE OF PRIVACY AND LEISURE.

THE SECOND THEORY IS THE "**ACTIVITY THEORY**" THAT SUGGESTS THAT THE PERSON BECOMES VERY ACTIVE AND DOES MORE DURING A DAY AT SIXTY-FIVE YEARS OF AGE THAN HE WOULD HAVE IMAGINED DOING WHEN HE WAS FORTY-FIVE. THESE TWO THEORIES ARE THE MOST SIMPLE TO EXPLORE AND ARE PROBABLY WORTH KNOWING ABOUT.

CAUTION: IT IS A QUESTION OF KNOWING MORE ABOUT THESE TWO STYLES OF DEALING WITH RETIREMENT RATHER THAN MAKING A VALUE JUDGMENT OR A BIAS IN PRESENTING THE QUESTION OF THE TWO THEORIES. THE THEORIES ARE ONLY ONE METHOD OF UNDERSTANDING HOW PEOPLE COPE WITH THEIR RETIREMENT YEARS. THERE ARE PROBABLY GOOD EXAMPLES OF BOTH STYLES IN YOUR OWN COMMUNITY. NEITHER IS RIGHT OR WRONG.

SESSION SIX

CARING FOR AGING PARENTS

THE TOPIC

THE TOPIC FOR THIS SESSION IS ONE THAT CAN BE FRAUGHT WITH EMOTION, GUILT, AND EVEN PAIN. WHO CARES FOR AGING PARENTS? HOW THAT CARE IS HANDLED BY THE FAMILY? AND WHAT IMPACT ALL OF THIS HAS ON THE OLDER PERSON'S LIFE? IS THE SUBJECT OF MUCH DEBATE IN MOST FAMILIES. THE RESPONSIBILITY FOR CARING IS THE TOPIC HERE.

THE FILM

THIS IS A 28-MINUTE DOCUMENTARY PRESENTING **FOUR** SEPARATE FAMILIES AND THEIR STORIES ABOUT CARING FOR THEIR AGING PARENTS.

STORY 1: ALZHEIMERS - LIVING AT HOME

THE FIRST STORY PRESENTS A FAMILY WHOSE PATERNAL GRANDFATHER HAS BEEN DIAGNOSED AS AN ALZHEIMER'S VICTIM. THE FAMILY OF TWO PARENTS AND FIVE TEENAGE CHILDREN CHOOSE TO HAVE THE GRANDFATHER LIVE WITH THEM AS LONG AS HE IS ABLE. THE SON OF THE OLDER MAN OR THE FATHER OF THE HOME REPORTS THAT HIS RELATIONSHIP WITH HIS FATHER HAS REALLY BEEN GOOD FOR THE WHOLE FAMILY.

> "MY FATHER NEVER TOLD ME THAT HE LOVED ME, AND SINCE HE HAS BEEN LIVING WITH US, HE HAS TOLD ME ON SIX SEPARATE OCCASIONS. NOW IF HE (THE GRANDFATHER) HAD BEEN LIVING IN A NURSING HOME, I WOULD HAVE MISSED THE OPPORTUNITIES," SAYS THE SON. (APPROXIMATE QUOTE)

STOP THE PROJECTOR OR VIDEO MACHINE -

QUESTIONS AFTER STORY 1:

1. WHO HAS TAKEN RESPONSIBILITY FOR CARING OR NURTURING IN THIS FAMILY? (THE MOTHER) AND WHAT DOES SHE SAY ABOUT CARING FOR THE AGING PARENT?

2. WHAT HAS HAPPENED TO THE FAMILY SINCE THE GRANDFATHER HAS COME TO LIVE WITH THEM?

3. WHERE ARE THE STRESS POINTS AND HOW IS THIS FAMILY ANDLING THEM?

STORY 2: DAY PROGRAMS AND SUPPORT GROUPS

THIS FAMILY HAS A MATERNAL GRANDMOTHER WITH ORGANIC BRAIN SYNDROME. THE GRANDMOTHER LIVES ON HER OWN BUT THE FAMILY (DAUGHTER AND SON-IN-LAW) WORRY THAT SHE WILL LEAVE THE GAS STOVE ON AND BURN HERSELF OR WORSE.

THEY FIND A DAY CARE FOR AGING PERSONS WHERE HER MOTHER SPENDS HER DAYS WITH OTHER OLDER ADULTS IN MEANINGFUL ACTIVITY. THIS RELIEVES SOME OF THE TENSION. HOWEVER, A MORE SERIOUS PROBLEM ARISES BECAUSE THE DAUGHTER AND THE MOTHER ARE OFTEN AT WIT'S END COPING WITH EACH OTHER'S BEHAVIOR. THE QUESTION IS WHAT TO DO? THE ANSWER FOR THE DAUGHTER IS A SUPPORT GROUP WHICH IS COMPOSED OF A PROFESSIONAL THERAPIST AND OTHER CHILDREN OF AGING PARENTS. ALL THE MEMBERS OF THE SUPPORT GROUP SHARE THEIR FRUSTRATIONS WITH CARING FOR AGING PARENTS IN AN ATMOSPHERE THAT IS NOT JUDGMENTAL WHILE BEING SUPPORTIVE. THEY CAN "VENT" OR LET OFF A BIT OF STEAM. THE RESULT IS THAT THEY CAN RETURN TO THEIR OWN SITUATIONS A LITTLE LESS ANGRY AND A LITTLE BETTER ABLE TO COPE.

QUESTIONS AFTER STORY 2 -

1. HOW HAS THE FAMILY DEALT WITH THE STRESS OF CARING?

2. HOW MIGHT A SUPPORT GROUP HELP IN YOUR OWN COMMUNITY?

Story 3: The Long-Term Care Facility - as a choice

This story presents a family that has to make a difficult choice about where mother is to live. As the daughters and their husbands are interviewed, it becomes increasingly clear that there is very little love between the mother and her children. They owe a debt of gratitude to her as their mother but none of them wants the mother to live with them. The choice of a residential facility is made and the family gathers to discuss their choice. This section of the film is rather painful to view for most people. The sadness comes from the desire of the middle-aged daughter explaining to her own daughter that if only Grandma would say a kind work and touch her, "it would be like coming home."

Questions after story 3 -

1. Is the residential care facility (nursing home) a good choice in some instances?
2. What about this family? Did they make a good choice?
3. Do you know any other families in this situation?

Story 4: Home Support and Courage

This story presents a woman who has "everything wrong with her" physically and yet she is a cheerful and important member of the family unit. Mrs. Geraldis is in her late eighties and lives with her widowed daughter who shares the rent and food bills with her. There is great support and obvious affection in

THIS FAMILY. YOU AND YOUR GROUP WILL MARVEL AT THE COURAGE OF THIS OLDER WOMAN AND THE LENGTHS TO WHICH HER FAMILY IS WILLING TO GO TO KEEP HER "OUT OF A NURSING HOME."

QUESTIONS AFTER STORY 4 -

1. DOES THE FAMILY APPEAR TO BE COPING WITH THE STRESS OF CARING FOR AN AGING PARENT? HOW?

2. WHAT COMMUNITY-BASED SUPPORTS ARE AVAILABLE TO THEM?

3. WHAT SUPPORTS ARE AVAILABLE TO YOU AND YOUR FAMILY IN YOUR COMMUNITY?

SESSION SEVEN

A STITCH IN TIME

THIS SESSION IS ALL DONE FOR YOU ON 1/2" VIDEOTAPE (FRENCH AS WELL AS ENGLISH)

OBJECTIVE

THIS SESSION IS DESIGNED TO GET PEOPLE THINKING ABOUT WHAT CAN HAPPEN IF A STROKE OR HEART ATTACK MAKES IT IMPOSSIBLE FOR AN OLDER PERSON TO COMMUNICATE HIS WISHES TO THE FAMILY ABOUT WHERE HE WANTS TO BE PLACED FOR CONVALESCENCE. SECONDLY, IT IS TO PROMOTE PLANNING AND OPEN DISCUSSION AMONG FAMILIES ABOUT WHERE "MOM OR DAD WOULD WANT TO BE."

METHOD

TWO DRAMATIC SCENES ARE PRESENTED IN THE VIDEO FOLLOWED BY QUESTIONS THAT APPEAR ON THE SCREEN. THE ANIMATOR SIMPLY SHUTS OFF THE VIDEO MACHINE AFTER EACH QUESTION.

SCENE ONE: **POOR OLD DAD** (THE VIDEO)

THIS SCENE DEPICTS AN OLDER MAN WHO IS FACING DISCHARGE FROM HOSPITAL AFTER BEING TREATED FOR A STROKE (CVA). THE DOCTOR TELLS HIM THAT HE WILL BE GOING HOME SOON BUT HE IS UNABLE TO COMMUNICATE WITH ANYONE SINCE HIS STROKE HAS LEFT HIS LEFT SIDE PARALIZED. HIS DAUGHTER AND SON ARRIVE AND PROCEED TO HAVE AN AGRUMENT ABOUT WHERE "DAD" WILL GO AFTER THE HOSPITAL. SINCE "DAD" CAN'T MAKE HIS WISHES KNOWN, HE IS PARTICULARLY FRUSTRATED AS HE WITNESSES THE DISAGREEMENT TAKING PLACE AT THE FOOT OF HIS BED.

QUESTIONS (AFTER SCENE ONE)

1. COULD **POOR OLD DAD** BE CONSIDERED A COMMON DAY OCCURRENCE?
2. COULD THE SON AND DAUGHTER BOTH BE RIGHT IN THEIR OPTIONS?
3. WHAT DO YOU BELIEVE DAD WOULD WANT?
4. HOW COULD THIS SITUATION HAVE BEEN PREVENTED?
5. HAVE YOU DISCUSSED YOUR FUTURE PLANS WITH ANYONE?

SCENE TWO: **DAD'S OPTIONS**

THIS SCENE IS VERY DIFFERENT. USING THE SAME CHARACTERS, THE AUDIENCE VIEWS AN OLDER MAN AND HIS ADULT CHILDREN HAVING A RATIONAL DISCUSSION AROUND HIS KITCHEN TABLE. THE QUESTION THE DAUGHTER AND SON HAVE IS: "IF SOMETHING SHOULD HAPPEN TO YOU, WHERE WOULD YOU LIKE TO GO TO RECOVER"? THE FATHER INDICATES, AFTER SOME LIGHTHEARTED MOMENTS, THAT HE WOULD PREFER TO RETURN TO HIS OWN HOME WITH SOME ASSISTANCE. THEY THEN LOOK INTO AN INFORMATION BROCHURE FROM THE DEPT. OF SOCIAL SERVICES (NEW BRUNSWICK).

QUESTIONS (AFTER SCENE TWO)

1. WHAT CHANGES COULD AFFECT A PERSON'S INDEPENDENCE?
2. COULD MOST PEOPLE DO WHAT THIS FAMILY DID? DISCUSS.
3. WHOSE RESPONSIBILITY IS IT TO BEGIN THE DISCUSSION ABOUT FUTURE PLANNING?

4. WHAT ARE THE RESOURCES THAT EXIST IN YOUR COMMUNITY?

5. HAS THIS PRESENTATION EFFECTED YOUR THINKING ABOUT FUTURE PLANNING FOR ELDERLY PEOPLE?

Credit should be given to Eric Gionet of the New Brunswick Department of Social Services for having developed this idea into a videotape.

SESSION EIGHT

NEW WRINKLES ON OLD ATTITUDES

THE TOPIC

OUR ATTITUDES ABOUT AGING ARE REFLECTED IN THE WORLD AROUND US: MAGAZINES, TELEVISION, AND NEWSPAPERS; AS WELL AS, THE ATTITUDES OF CAREGIVERS OF ALL SORTS AND SIZES. CAREGIVERS COME IN MANY FORMS. SOME ARE DOCTORS, NURSES, SOCIAL WORKERS AND SOME ARE FAMILY MEMBERS AND NEIGHBORS. WE ALL HAVE ATTITUDES THAT COULD DO WITH SOME CLARIFYING AND PERHAPS EVEN SOME IMPROVING.

RESOURCES: SIXTY-SECOND ISLAND TEL COMMERCIAL (3/4" VIDEO)

NEW WRINKLES ON OLD ATTITUDES (30-MINUTE KEYNOTE ADDRESS AT SYMPOSIUM '85 - CH'TOWN) BY DR. GEORGE MERRY, GERIATRICIAN, KINGSTON, ONTARIO (3/4" VIDEO).

MAGAZINES: FROM HOME.

TV COMMERCIAL - ISLAND TEL

SHOW THE COMMERCIAL - QUESTIONS FOR DISCUSSION:

1. WHAT DID THE FATHER TEACH THE SON?
2. WHAT DID THE MOTHER TEACH HIM? SHOW THE COMMERCIAL AGAIN.
3. IS THERE A STATEMENT ABOUT THE RELATIONSHIP BETWEEN THE GENERATIONS IN THIS COMMERCIAL?

   POSITIVE OR NEGATIVE?

   DISCUSS.

NEW WRINKLES ON OLD ATTITUDES : 30 MINUTES

SHOW VIDEOTAPE: 3/4"

DR. GEORGE MERRY PRESENTS SOME FRESH IDEAS ABOUT HOW WE VIEW THE OLD AND THE PROCESS OF AGING. THE AUDIENCE TO WHOM HE IS ADDRESSING HIS REMARKS IS MOSTLY HEALTH CARE PROFESSIONALS; HOWEVER THE TAPE CONTAINS SOME VERY GOOD STATEMENTS FROM WHICH ALL OF US CAN BENEFIT.

QUESTIONS AFTER THE VIDEO:

1. HOW DO YOU FEEL ABOUT THE "MORE SO" THEORY AS PRESENTED BY DR. MERRY?

2. DO PEOPLE REALLY CHANGE OR DO THEY REMAIN ESSENTIALLY THE SAME--ONLY OLDER?

3. DO YOU FEEL THAT CAREGIVERS NEED TO HAVE THEIR ATTITUDES ABOUT THE ELDERLY CHANGED?

   CAN YOU GIVE SOME EXAMPLES.

4. HOW WOULD YOU IMPROVE THE SITUATIONS THAT YOU DESCRIBED IN QUESTION 3.

MAGAZINES FROM HOME

INVITE PARTICIPANTS TO BRING IN MAGAZINES FROM HOME (EG, CANADIAN LIVING, MACLEANS, ATLANTIC INSIGHT, ETC.) AND TO DEPOSIT THEM ON A CENTRAL TABLE IN THE ROOM.

THE QUESTION IS SIMPLE: FIND IN THE MAGAZINES EXAMPLES BOTH POSTITVE AND NEGATIVE OF STATEMENTS ABOUT AGING. YOU MIGHT LEAD OFF THE SESSION BY FINDING AN EXAMPLE OF AN AD OR A PICTURE THAT YOU FEEL DEPICTS A RATHER DECREPIT AND STEREOTYPED OLD PERSON.

REMEMBER MAGGIE KUHN'S SIX STEREOTYPES OF AGING (SESSION 3). SHE SAID THAT OLD PEOPLE ARE SEEN AS DISEASED, MINDLESS, SEXLESS, USELESS, POWERLESS, AND SOMEWHAT THE SAME AS ALL OTHER OLDER PEOPLE.

ON THE OTHER HAND, YOU MAY WANT TO FIND A VERY POSITIVE EXAMPLE OF AN ADVERTISEMENT OR A PICTURE OF AN OLD PERSON, EG,

> A GRANDPARENT AND CHILD IN CONVERSATION ABOUT SOMETHING THAT IS OBVIOUSLY IMPORTANT TO BOTH. THE PICTURE ENCLOSED MIGHT BE A STARTING POINT FOR YOU. EMPHASIZE THE RELATIONSHIP ILLUSTRATED BY THE PHOTO. THE YOUNG BOY ON THE FAR RIGHT HAS A LOOK OF WONDER ON HIS FACE FOR THE OLD SKIPPER WHO IS LIGHTING HIS PIPE.

THIS EXERCISE SHOULD SERVE TO EMPOWER THE PARTICIPANTS TO SEE THE DAILY NEWS OR READ MAGAZINES WITH A MORE CRITICAL EYE.

QUESTIONS:

1. ARE THERE ANY TV COMMERCIALS THAT YOU FEEL MAKE A POSITIVE STATEMENT ABOUT OLD PERSONS?

   GIVE SOME EXAMPLES.

2. WHAT ABOUT NEGATIVE STATEMENTS ABOUT AGING?

3. ARE THERE ANY TV SHOWS (THE GOLDEN GIRLS) THAT MAKE POSITIVE STATEMENTS ABOUT AGING?

   WHAT IS THE NATURE OF THIS POSITIVE STATEMENT?

   REFER TO MAGGIE KUHN'S LIST OF MYTHS AGAIN FROM SESSION 3.
   DISEASED ..... MINDLESS ..... SEXLESS
   USELESS ..... POPWERLESS ..... AND SOMEWHAT
   THE SAME AS ALL OTHER OLDER PEOPLE .....